

**UTILIZATION MANAGEMENT: BARRIERS TO CARE
AND BURDENS ON SMALL MEDICAL PRACTICES**

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CONTENTS

OPENING STATEMENTS

	Page
Hon. Nydia Velázquez	1
Hon. Steve Chabot	2

WITNESSES

Dr. Paul M. Harari, Professor, Chairman, Department of Human Oncology, University of Wisconsin School of Medicine and Public Health, Madison, WI, testifying on behalf of the American Society for Radiation Oncology (ASTRO)	4
Dr. David R. Walega, MSCI, Associate Professor of Anesthesiology, Chief, Division of Pain Management, Vice Chair of Research, Department of Anesthesiology, Northwestern University Feinberg School of Medicine, Chicago, IL, testifying on behalf of the American Society of Anesthesiologists	6
Dr. John S. Cullen, FAAFP, Family Physician & Partner, Valdez Medical Clinic, LLC, Valdez, AK, testifying on behalf of the American Academy of Family Physicians	7
Dr. Howard Rogers, PhD., FAAD, Owner, Advanced Dermatology, LLC, Norwich, CT, testifying on behalf of the American Academy of Dermatology Association	9

APPENDIX

Prepared Statements:

Dr. Paul M. Harari, Professor, Chairman, Department of Human Oncology, University of Wisconsin School of Medicine and Public Health, Madison, WI, testifying on behalf of the American Society for Radiation Oncology (ASTRO)	27
Dr. David R. Walega, MSCI, Associate Professor of Anesthesiology, Chief, Division of Pain Management, Vice Chair of Research, Department of Anesthesiology, Northwestern University Feinberg School of Medicine, Chicago, IL, testifying on behalf of the American Society of Anesthesiologists	37
Dr. John S. Cullen, FAAFP, Family Physician & Partner, Valdez Medical Clinic, LLC, Valdez, AK, testifying on behalf of the American Academy of Family Physicians	42
Dr. Howard Rogers, PhD., FAAD, Owner, Advanced Dermatology, LLC, Norwich, CT, testifying on behalf of the American Academy of Dermatology Association	52
Questions for the Record: None.	
Answers for the Record: None.	
Additional Material for the Record:	
America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA)	60
American Academy of Ophthalmology	67
American Physical Therapy Association (APTA)	72
Consensus Statement on Improving the Prior Authorization Process	81
Dr. Josh Bailey, PT, DPT, CEO, Rehabilitation Associates on behalf of the Virginia Physical Therapy Association	85
Final Stakeholder of the American Association of Neurological Surgeons/ Congress of Neurological Surgeons	89

UTILIZATION MANAGEMENT: BARRIERS TO CARE AND BURDENS ON SMALL MEDICAL PRACTICES

WEDNESDAY, SEPTEMBER 11, 2019

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The committee met, pursuant to call, at 11:32 a.m., in Room 2360, Rayburn House Office Building. Hon. Nydia Velázquez [chairwoman of the Committee] presiding.

Present: Representatives Velázquez, Finkenauer, Kim, Davids, Chu, Evans, Schneider, Delgado, Houlahan, Craig, Chabot, Balderson, Hern, Hagedorn, Stauber, Burchett, and Joyce.

Chairwoman VELÁZQUEZ. Good morning. The committee will come to order.

I thank everyone for joining us this morning, and I want to especially thank the witnesses who have traveled from across the country to be here with us today.

On this committee, we are focused on breaking down barriers that many small businesses face. Whether it is ensuring small firms have access to affordable capital or reducing regulatory burdens, our focus on this committee is to create a thriving Main Street that makes towns and communities across the country better places to live, work, and raise a family.

An essential part of any community are the doctors who are relied upon in every corner of our country to keep us healthy. But what many people forget is that many doctors, especially in rural and underserved communities, are themselves small businesses. They face the same challenges that any small employer encounters—making payroll, paying rent, managing overhead expenses, while also dealing with the same regulations that larger hospitals can manage through bigger budgets and more resources. However, when doctors spend hours dealing with paperwork or cannot treat a patient because a health insurance company will not approve a treatment, the result is patients suffering.

And that is why we are here today—to discuss a barrier preventing family physicians and specialists from providing critical care to their patients. Prior authorization is a cost-savings tool used to reduce healthcare spending through improper payments and unnecessary care. Before doctors can provide even routine care procedures, diagnostic tests, or prescriptions, they must first obtain approval from a patient’s insurer. While in some cases this process leads to appropriate treatments, reduces costs by eliminating ex-

pensive tests or unnecessary prescriptions, it also is putting an undue burden on physicians, their staff, and patients.

It is not uncommon that patients now face delays of 2 weeks and sometimes over a month before getting treatment. In fact, more than 25 percent of doctors report that prior authorization has led to a serious adverse event for a patient in their care. And, 82 percent report the burdens associated with prior authorization lead to delayed care. Meanwhile, doctors are sitting on hold with insurance companies to explain why their patient needs a certain treatment.

Sadly, this is an issue impacting doctors practicing in nearly every area of medicine in every part of the country. It affects each doctor paid by insurance, but is especially problematic for small group and solo practitioners that simply do not have the resources to hire additional administrative staff.

Between the massive student loan debt many doctors face and these administrative burdens, it is no wonder that many doctors are deterred from pursuing the great American dream—to own and operate their own business.

By 2030, the Association of American Medical Colleges expects the workforce shortage to expand to over 100,000 doctors nationwide. One way to combat this growing problem is to empower small private practices to fill the gaps. They can do this with common sense policies that streamline the prior authorization process—making it easier for them to do what they were trained to do—keep our communities healthy.

I support reducing costs because our country spends nearly double the amount per person in health care than any other industrialized nation, yet our population ranks near the bottom in health outcomes compared to other high-income countries.

There are reasonable ways to reduce costs such as increasing transparency in pricing so that consumers know what they are paying, allowing the government to negotiate the prices of prescription drugs so that our seniors can access affordable prescriptions, and increasing the use of technology.

I am excited to hear about the potential solutions to this problem so that patients can get the care they need. I look forward to hearing about how we can modernize and streamline this process so that doctors can stop wasting time haggling with health insurance companies and continue to make the lives of patients and their families better.

Again, I want to thank the witnesses for being here today, and I now yield to the Ranking Member, Mr. Chabot, for his opening statement.

Mr. CHABOT. Thank you, Madam Chair.

We are here today to hear from medical professionals about the burdens experienced by small medical practices, especially utilization management. The medical field is an integral part of our everyday lives. All participants from world renowned surgeons to clerical and administrative staff in this field deserve recognition for their diligent efforts to save lives.

As we in Ohio know all too well, medical professionals are on the frontlines fighting the opioid epidemic. In 2016, there were over 42,000 deaths due to opioid overdose. This statistic is one of the reasons prior authorization has been implemented to help those in

my home state and across the nation. Methods such as STEP therapy and prior authorization were introduced to reduce unnecessary procedures, prevent oversubscription of dangerously addictive drugs, and reduce human error.

However, despite the reasoning for these processes, more must be done to streamline communication between practices and insurance providers. Many small medical practices struggle to afford necessary staff to complete the almost 60 extra hours spent per week on administrative tasks. Doctors spend extra time on the complex processes and paperwork required for prior authorization instead of tending to their patients. Patients become frustrated and 40 percent will abandon prescriptions requiring prior authorization at the pharmacy.

While this may sound grim, there is still hope, and we are looking for solutions. Increased collaboration between private insurers and organizations like the AMA can ensure prior authorization requests are based on sound medical science.

I want to thank the witnesses for sharing their experiences with us here, if we ever stop talking. I look forward to discussing solutions to reduce the burdens on small providers and ensure a more efficient healthcare system.

And Madam Chairwoman, I appreciate you holding this hearing. I think this is one of the more important hearings that we have had this year. So, thank you for doing that. And thank the witnesses for coming today.

Chairwoman VELAZQUEZ. Thank you, Mr. Chabot.

The gentleman yields back.

And if committee members have an opening statement prepared, we will ask that they be submitted for the record.

I would like to take a minute to explain the timing rules. Each witness gets 5 minutes to testify and members get 5 minutes for questioning. There is a lighting system to assist you. The green light will be on when you begin, and the yellow light comes on when you have 1 minute remaining. The red light comes on when you are out of time, and we ask that you stay within the timeframe to the best of your ability.

I would now like to introduce our witnesses.

Our first witness is Dr. Paul Harari. Dr. Harari is the Jack Fowler Professor and Chairman of the Department of Human Oncology at the University of Wisconsin School of Medicine and Public Health. He joined the faculty at the University of Wisconsin in 1990 and became an endowed professor in 2003 and the Department Chairman in 2007. His clinical and laboratory research focuses primarily on treatment advances for head and neck cancer patients.

Thank you, Dr. Harari, for being here today.

Our second witness is Dr. David Walega. Dr. Walega is currently the Chief of the Division of Pain Medicine at Northwestern Medicine and the Vice Chair of the Department of Anesthesiology at Northwestern University Feinberg School of Medicine in Chicago, where he has been a faculty member since 2003. He earned his medical doctorate from Wayne State University in Detroit in 1993 and completed an internship in internal medicine and a residency at Northwestern University. He is a dedicated medical educator

and holds the rank of associate professor at Northwestern University, where he has published numerous manuscripts and book chapters on pain-related topics and has lectured nationally and internationally.

Thank you, Dr. Walega, for being here this morning.

Our third witness is Dr. John Cullen, a family physician in Valdez, Alaska, and the president of the American Academy of Family Physicians, which represents 134,600 physicians and medical students nationwide. Dr. Cullen earned his Bachelor of Science in molecular and cell biology from the University of California-San Diego. He earned his medical degree from the University of Arizona College of Medicine-Tucson.

Thank you, Dr. Cullen, for being here this morning.

And now I yield to our Ranking Member, Mr. Chabot, to introduce our final witness.

Mr. CHABOT. Madam Chairwoman, our final witness is Dr. Howard Rogers, testifying on behalf of the American Academy of Dermatology. Dr. Rogers is a graduate of Harvard University and holds both an MD and PhD from Washington University School of Medicine. Dr. Rogers completed a fellowship in my congressional district at the University of Cincinnati Hospital. He now owns a private dermatological practice in Connecticut, where he has treated approximately 35,000 cases of skin cancer in the last 19 years.

We welcome you here, Dr. Rogers, and thank you for testifying today.

Chairwoman VELÁZQUEZ. Thank you, Mr. Chabot.

Dr. Harari, you are now recognized for 5 minutes.

STATEMENTS OF DR. PAUL M. HARARI, PROFESSOR, CHAIRMAN, DEPARTMENT OF HUMAN ONCOLOGY, UNIVERSITY OF WISCONSIN SCHOOL OF MEDICINE AND PUBLIC HEALTH; DR. DAVID R. WALEGA, MSCI; ASSOCIATE PROFESSOR OF ANESTHESIOLOGY, CHIEF, DIVISION OF PAIN MANAGEMENT, VICE CHAIR OF RESEARCH, DEPARTMENT OF ANESTHESIOLOGY, NORTHWESTERN UNIVERSITY FEINBERG SCHOOL OF MEDICINE; DR. JOHN S. CULLEN, FAAFP, FAMILY PHYSICIAN & PARTNER, VALDEZ MEDICAL CLINIC, LLC; DR. HOWARD ROGERS, PHD, FAAD, OWNER, ADVANCED DERMATOLOGY, LLC

STATEMENT OF DR. PAUL M. HARARI

Dr. HARARI. Chairwoman Velázquez, Ranking Member Chabot, and esteemed members of the Small Business Committee, thank you very much for the opportunity to testify before you today on barriers to health care and burdens on the physicians. I am testifying on behalf of the American Society for Radiation Oncology (ASTRO). I serve as the Chairman of ASTRO's Board of Directors and Professor and Chairman of Radiation Oncology at the University of Wisconsin.

ASTRO represents more than 10,000 members who strive to give cancer patients the best possible care to advance the science of oncology. ASTRO's membership includes radiation oncologists, nurses, biologists, medical physicists, and other healthcare professionals who specialize in treating patients with radiation therapy. Our

members work in hospitals, academic research institutions, private practices, and this year, more than 1.7 million people will be diagnosed with cancer in the U.S., and roughly 1 million of these will receive radiation therapy.

Today, I wish to share with you a major problem that you have identified today. This one also facing the field of radiation oncology, prior authorization. While the system may have been designed as a path to streamline healthcare, in fact, it is frequently harmful to cancer patients in receiving treatment.

There are three issues I would like to highlight today.

First, prior authorization wastes precious time that physicians could be devoting to patient care.

Second, delays in cancer care can have negative impacts on patient outcomes.

And third, this disproportionately impacts providers in small community practice settings.

Prior authorization has become an overly bureaucratic process that requires physicians to obtain approval from health insurance companies to prescribe a specific treatment, procedure, or medication. Radiation oncologists are increasingly restricted from exercising their clinical judgment in the best interest of their patients. Instead, insurance companies and third-party payers are making clinical decisions for these cancer patients. Who would you want to make cancer care decisions for you—your insurance company or your cancer physician?

In a recent ASTRO survey, 9 of 10 radiation oncologists reported patient treatment delays due to the prior authorization process. In cancer care, timely treatment matters. Yet, prior authorization practices are delaying patients from receiving life-saving therapies, literally putting the lives of millions of people at risk.

In my own practice at the University of Wisconsin Comprehensive Cancer Center we have 16 busy radiation oncologists who routinely face treatment delays for their patients related to prior authorization. Let me provide a personal example. When a prior authorization is denied despite the best efforts of my administrative staff and resident physicians, I may be called upon to conduct a peer-to-peer review by phone. This occurred for a patient of mine with a complex base of skull tumor. The peer reviewer was a thoughtful general practitioner who was unfamiliar with base of skull chordoma and unfamiliar with radiation and asked me for several minutes about the tumor, the natural history, the anatomy, the normal structures nearby, and before concluding said, Dr. Harari, you are obviously highly expert in this area. I will authorize the radiation treatment just as you prescribe. Meanwhile, my patient had been anxiously awaiting for 8 days while that tumor was growing to learn confirmation that they could receive the prescribed cancer treatment that was recommended.

The problems associated with prior authorization are so pervasive that 2/3 of radiation oncologists surveyed have had to hire new staff to handle these requests. In an era of value-based care, where is the value when we are increasing costs to deliver care without any added clinical benefit? The issue of prior authorization is concerning for patients who receive treatment in private practices who often have less staff to handle these requests.

In 2018, a report from the Office of the Inspector General stated that Medicare Advantage organizations may have an incentive to deny preauthorization of services in order to increase profits. In the same report, it was revealed that CMS had acknowledged widespread and persistent performance problems related to inappropriate denials of care and payment.

In conclusion, legislation is needed to relieve radiation oncology patients and physicians of the burden from restrictive prior authorization. Members of this body can put themselves in the shoes of a newly diagnosed cancer patient to appreciate the significantly negative impact that treatment delays can have on their lives. ASTRO looks forward to working with policymakers and stakeholders to develop policy-based solutions to fix this broken system.

Thank you very much.

Chairwoman VELAZQUEZ. Thank you very much, Dr. Harari.

Dr. Walega, you are now recognized for 5 minutes.

STATEMENT OF DR. DAVID R. WALEGA

Dr. WALEGA. Chairwoman Velázquez, Ranking Member Chabot, and members of the Committee, thank you for the opportunity to testify before the House Committee on Small Business today. I offer this testimony on behalf of the American Society of Anesthesiologists (ASA) and my colleagues who practice pain medicine.

Physicians like me are all too familiar with the burdens of prior authorization and the toll it takes on our patients and our medical practices. Because of our current broken insurance system, physician time and practice resources are increasingly allocated to fighting insurers instead of caring for patients. It is a system built to fail.

Presently in medicine we are facing dual crises. First, we have the opioid epidemic. Second is the crisis of chronic pain. The most recent statistics on the prevalence of chronic pain conditions in the United States is staggering.

I would like to tell you about a patient of mine who I will call Betsy, to illustrate the complicated interaction of these dual crises and the predicament many pain specialists like me encounter daily.

Betsy is 38. She came to me with a 10-year history of back pain and nerve pain in her legs following a failed spine fusion surgery. When I saw her she was dependent on high doses of opioids to manage her pain, and despite these high doses, her pain was not under control. She felt hopeless. She had seen multiple doctors and the cycle of this pain had been going on for years. That day in my office she tearfully pleaded, is there anything you can do for me? After examining her, I knew Betsy would be an ideal candidate for a non-opioid treatment for chronic pain called spinal cord stimulation (SCS). This is a treatment in which we surgically place small stimulating electrodes adjacent to the spinal cord to deliver imperceptible electrical impulses to the spinal cord to block pain signals from being transmitted to the brain.

To make sure this treatment would be effective for Betsy, I recommended that she taper her opioids by at least 50 percent before we would proceed with treatment as high doses of opioids can cloud the effects of stimulation. Surprisingly, that day she tapered completely off of all of her medications. Per standard practice, I first

implanted a temporary spinal cord stimulating system for a 10-day trial. Her health insurance provider did approve this. During the trial, we want to see at least a 50 percent reduction in a patient's pain with a commensurate improvement in their physical function.

In Betsy's case, the gains with her temporary trial were nothing less than astounding. She became a completely different person. Her face had brightened, she moved around my office with ease. I heard her laugh for the first time. She told me that during the trial she went for walks around the neighborhood with her husband, something she had not been doing for years. She was able to play with her two children who have special needs. For those 10 days she had her life back and she was ecstatic.

So I submitted the required forms and letters of medical necessity to her insurer to obtain authorization to implant a permanent spinal cord stimulation system. That implant was denied by her insurer. I appealed the denial which was denied again. I appealed again and requested a peer-to-peer review. The concept behind the peer-to-peer review is that another physician chosen by the insurer objectively reviews the medical necessity of a proposed treatment and speaks directly to me, the provider.

Unfortunately, peer-to-peer is a misnomer as the physician reviewer, as previously stated, is usually not a similarly trained or experienced specialist in the field. In fact, I have had a general pediatrician review prior cases like this one.

In Betsy's case, the appeals process took 8-1/2 months. Feeling hopeless and experiencing intolerable levels of pain again after the temporary system was removed, Betsy went back on opioids to control her pain. She lost hope all over again even though we had a proven treatment that was effective for her.

It was my appeal to the medical director to her insurance company that got the treatment finally approved. Today, Betsy has her spinal cord stimulator. She is not taking opioids. She is taking care of her kids. She is independent and she is returning to the workforce. She has her life back. Betsy's ultimate clinical outcome is the reason I became a physician, to help patients live their best lives despite an underlying medical condition.

Physicians do not have the resources to fight this type of fight for every single patient, not in our current practice environment. These appeals take precious time away from providing care that other patients need, and for these reasons I am appreciative that the Committee is looking critically at this issue.

In my submitted written testimony, I have included specific recommendations to remove barriers to comprehensive multidisciplinary pain care, as well as substance use disorder treatment. And I thank you for your consideration this morning.

Chairwoman VELAZQUEZ. Thank you, Dr. Walega.

Dr. Cullen, you are now recognized for 5 minutes.

STATEMENT OF DR. JOHN S. CULLEN

Dr. CULLEN. Chairman Velázquez, Ranking Member Chabot, and members of the Committee, I am honored to be here today representing the 134,600 members of the American Academy of Family Physicians.

I am a practicing family physician in Valdez, Alaska, a community of about 4,000 people. I am also a small business owner and a partner of the Valdez Medical Clinic, LLC, and along with five family physician colleagues, we are the sole providers for a geographically isolated community 300 miles from the nearest tertiary care hospital, and the area we serve is about the size of Ohio.

The AFP welcomes this hearing on utilization management as an important and necessary step towards reducing both barriers to care for patients and the administrative burdens for family physicians. As I detail in the written testimony, family physicians and their patients face a daunting array of administrative barriers to appropriate and necessary medical care. The result has been chaos in caring for our patients, burnout for family physicians, and worse outcomes for patients. Ask any practicing family physician about preauthorization and you are going to get an earful.

Prior authorization is a major reason that small practices like mine are closing. In my own practice, a patient of mine had a combination of Crohn's Disease and severe psoriasis and we eventually controlled both disorders with a monoclonal antibody therapy after years of trying multiple other regimens and with consultation with multiple specialists. After 2 years, we had to reauthorize this medication which had been working so well, and that resulted in a delay of months, during which her condition worsened. And when we finally were able to get her back on the medication, she had a serum sickness reaction and suffered anaphylactic shock and we almost lost her. And she can now never use this medication that was working so well.

Most family physicians in private practice have contractual relationships with seven or more insurance companies, including Medicare and Medicaid, and now our practice, and again, I am in a town of 4,000 people, has 35 different insurance plans we deal with, each of which has its own system of prior authorization and drug formularies, and which change on a regular basis. I often do not know in advance which medications in which class will be covered, and this often means that when I wrote a prescription, my patient has to take it to the pharmacy to find out if it is covered. And if it is not, then I need to find an alternative often by writing a new prescription and the process gets repeated.

We use electronic preauthorization but we do not often get a timely answer and this leads to a phone call by me or one of my staff to a reviewer who often has a very hazy idea about the difference between generic and tradenames or even what the medication does.

My patients rarely blame their insurance company for this administrivia. They blame me for not getting them the medications they need, yell at my staff, or just stop taking the medications they need to prevent hospitalization. And this is the hidden cost of prior authorization. My staff burn out and quit because of the frustration inherent in this crazy system, compounded by being yelled at by patients for not having their medications.

So I was just told before I came here that my nursing supervisor is quitting next month. And she and one of my MAs is spending their entire time just doing prior authorizations. And that is not what she trained for.

In the recent 2019 AFP survey, administrative burden was by far the top issue facing family physicians, of which EMRs and prior authorizations for medications, durable medical equipment, and procedures such as imaging were the most impactful. Prior authorization for durable medical equipment typically requires a physician to fill out a paper form or submit specific data for approval, and each DME company has different data requirements for submission. We are being pelted with DME forms.

Family physicians simply want to be able to prescribe efficiently and effectively what their patients need to help them manage their condition in a way that maintains their health.

And we know how to fix it. America's frontline physicians have developed joint principles on reducing administrative burden in health care. The AFP strongly urges the adoption of the prior authorization and STEP therapy recommendations that we shared in our written testimony. We call for prior authorizations to be minimized, standardized, and universally electronic to promote efficiency and reduce administrative burdens that direct valuable resources away from patient care and can inadvertently lead to negative patient outcomes.

We support the Improving Seniors Timely Access to care Act, H.R. 3107. It is a bipartisan effort. It is a step in the right direction and will protect Medicare Advantage patients by streamlining prior authorization practices.

The prior authorization practice is out of control. It is increasing, and rather than a tool for preventing unnecessary or expensive care, prior authorizations negatively impact patients' health, and is a significant cause for family physician burnout and the closure of small private practices.

So thank you very much for your interest in reducing both barriers to care for patients and administrative burdens on family physicians.

Chairwoman VELÁZQUEZ. Thank you, Dr. Cullen.

Dr. Rogers, you are now recognized for 5 minutes.

STATEMENT OF DR. HOWARD ROGERS

Mr. ROGERS. Thank you, Chairwoman Velázquez, Ranking Member Chabot, and members of the Small Business Committee, for the opportunity to speak before you today on behalf of the American Academy of Dermatology Association.

I am Dr. Howard Rogers, board-certified dermatologist, and I own a small private practice, Advanced Dermatology, in Connecticut. As a small business owner, I appreciate the Committee's efforts to prioritize reducing administrative burden such as utilization management processes. My testimony will focus on how increasing administrative burdens are impacting small medical practices such as my business, and more importantly, I will highlight how prior authorizations delay necessary care for patients.

Physicians' practices are on the frontlines of the healthcare system. Right now, while our country is grappling with how to increase patient access to high quality care while reducing costs, my colleagues and I are forced to comply with utilization management systems that seem designed to force doctors out of practice.

I and other physicians in my practice dedicate at least 15 hours a week on prior authorizations alone. Prior auths drive up the cost of running a medical practice. They routinely delay critical patient care and contribute to physician burnout while providing no increase in quality of care.

Dermatologists diagnose and treat more than 3,000 diseases. For many skin diseases and conditions, the medications are specialized and their use is highly nuanced, and it is dependent on numerous factors specific to the patient and his or her disease. Prior authorization policies place a third party in the decision-making position with little or no understanding of the complexity or full history of a patient's condition.

So just imagine seeing a patient in your office with a severely painful condition or a rapidly spreading infection. You prescribe a highly effective medication, you walk the patient through how they are going to use that medication, and you assure the patient that they are going to soon feel better. Then the following scenario occurs. The prescription is denied because prior authorization is required and you try for days or weeks to get that medication approved while the patient continues to suffer. The patient goes to the pharmacy repeatedly and is told that the medication is denied, is no longer covered, requires a prior authorization, and there is nothing they can do about it. You can imagine the frustration and desperation of patients when they are at their most vulnerable.

So in my office, my staff spent 70 hours a week, 70 hours a week on prior auths alone. I have had to hire two full-time staff at the cost of \$120,000 a year with salary and benefits to handle the volume of prior auths. These funds could definitely be better spent on staff education, improved benefit packages for staff, new medical equipment, technology, all those things that bring us forward as physicians.

We appreciate Congress working to help alleviate the prior authorization burdens by including language to create a standardized electronic prior authorization form for Medicare or prescription drugs in the support for Patients and Communities Act which passed in October 2018.

Prior authorizations are also delaying patient access to necessary dermatologic procedures. Mohs micrographic surgery is a technique that dermatologists use to surgically excise skin cancers, ensuring in real time that the malignancy is fully treated while sparing as much healthy tissue as possible. Typically, Mohs surgery does not require a prior auth. However, the reconstruction of the defect left after the surgical excision does. And since the physician does not know the extent of the repair procedure that will be needed prior to the surgery, obtaining the prior authorization is not possible. And so this leaves the physician, me, with a patient with a hole in their skin and no authorization to repair it. By prohibiting plans from requiring prior authorization during skin cancer surgery, patients will be ensured the best chance of positive outcome.

To address this burden, we ask the members of the Committee to support the Improving Seniors Timely Access Care Act (H.R. 3107). This legislation aims to relieve prior authorization burdens for procedures under Medicare Advantage Plans, as well as to provide transparency to patients and providers.

So it is impossible for me to capture in these remarks how the prior authorization process hinders the practice of medicine. Even with the extra support staff, the providers in my practice are regularly disrupted from patient care to deal with prior auths. In fact, 1/4 of all communications in my office, be it phone calls, faxes, emails, EMR notifications, payer portals, they are all associated with prior authorizations.

And the kicker is that most of my patients' prescriptions and repairs eventually get approved but only after exhaustive efforts of calling insurers and appealing denials. However, the process truly wears down my colleagues and staff to the point where I worry about burnout for them. We became physicians to help patients, not complete paperwork. And the constant struggle has become too much for many of my colleagues, including my practice partner who is retiring despite being in good health and loving seeing his patients. Prior authorization ultimately ends up costing the healthcare system more than it saves.

So on behalf of the American Academy of Dermatology Association, I thank you for holding this hearing and your interest in safeguarding physicians and patients from unnecessary utilization management practices. And I am happy to answer any questions.

Chairwoman VELAZQUEZ. Thank you, Dr. Rogers.

Let me take this opportunity to thank all of you for your insightful testimonies, and specifically for putting a human face into the issue of prior authorization.

I would like to ask each one of you, how often do you have to delay the start of treatment because of the prior authorization process?

Dr. HARARI. Chairwoman, the survey that ASTRO conducted of all radiation oncologists recently identified that 9 in 10 radiation oncologists have patients with treatment delays. As many as 2/3 of patients will experience a delay in the start of their cancer treatment related to prior authorization.

Chairwoman VELAZQUEZ. Yes?

Dr. CULLEN. And I guess I am speaking just from a personal perspective but we have at least three or four a day if not more, just in my own, the patients that I am seeing.

Chairwoman VELAZQUEZ. So in your view, are these health insurance companies that you have to deal with equipped to determine the course of action or the course of treatment that is best for your patients?

Dr. WALEGA. I would like to answer that.

Chairwoman VELAZQUEZ. Has there been any study conducted to that effect?

Dr. WALEGA. As far as studies, I do not know but as I think we all commented, the individuals who are ultimately making the decision about our patients' fate and how their health care will be directed is made by someone who does not do what we do. They do not see the patient. They probably have not looked at the medical records that we have sent to them repeatedly, and they often do not know the latest technology that we are applying in these cases of treatment.

Chairwoman VELÁZQUEZ. So are you telling me that you do not know what type of data or scientific evidence the health insurance companies are using when making a decision?

Dr. HARARI. I can tell you that there is very strong, robust scientific data that delaying cancer treatment can decrease survival. There are dozens of papers identifying each week of delay for fast growing tumors can knock off 1 or 2 or 3 percent of the cure aid. I am aware of no scientific data that the insurance companies provide as to why those delays are acceptable.

Chairwoman VELAZQUEZ. In a 2018 report, and I believe that some of you mentioned it, the OIG stated that, and I quote, "Medicare Advantage organizations may have an incentive to deny preauthorization of services in order to increase profits."

To the entire panel, based on your experience, do you find this to be true? In other words, is this cost-saving measure used by insurers really a disguise that allows them to increase their profits at the expense of patients? And at the expense of the bottom line of your practices?

Dr. HARARI. I am sorry to say that I think that this is true. This is certainly the experience of the radiation oncologists across the U.S. that were surveyed, identifying that 2/3 of the prior authorization denials were subsequently overturned on appeal, suggesting that the incentives that are derived by healthcare benefit managers may be prioritizing their actions over what is best for the individual cancer patient.

Chairwoman VELAZQUEZ. Yes, Dr. Cullen?

Dr. CULLEN. So I think for us one of the best examples is albuterol. Albuterol is an inhaler used for asthma. But I have to decide whether the insurance company will accept albuterol or whether they will accept ProAir or whether they will accept Ventolin. They are all the same thing. But it really depends on which one that insurance company will accept at that moment in time. And a lot of that is based on agreements that they have with pharmacy benefit managers.

Another good example is we start joking about the PPI de jour. That is the proton pump inhibitor of the day because those change on a regular basis. We are never informed about what those changes are but these are common medications.

I was talking earlier that I had to preauthorize hydrochlorothiazide which is a blood pressure medication that has been used forever and has a great safety track record. It is very inexpensive, but I had to prior authorize even that medication as a generic. So unfortunately, I think that that is the case.

Chairwoman VELAZQUEZ. Dr. Rogers?

Mr. ROGERS. Unfortunately, there is little or no transparency in how the prior authorizations are judged, nor the guidelines by which the reviewers look at the clinical information provided. It seems haphazard, and it is designed to wear the physician down to the point where care is not rendered, which would definitely increase profitability for the insurers.

Chairwoman VELAZQUEZ. I do not have much time left but I would like to ask the following question and see which one of you would like to answer.

Do the third-party benefit management companies, Medicare Advantage plans, hired to conduct prior authorization also have this perverse incentive?

Dr. HARARI. I believe so because it is reflected in the overwhelming number of prior authorization denials that are then subsequently overturned after 2 to 3 weeks of fussing back and forth.

Chairwoman VELAZQUEZ. I ran out of time. Thank you so very much.

And now I recognize the Ranking Member, Mr. Chabot.

Mr. CHABOT. Thank you, Madam Chair.

Dr. Rogers, I will go with you first. In your opening statement you mentioned not being able to complete surgery for the patient because of prior authorization. Could you explain how on an everyday basis this actually works in the office and what specifically about prior authorization hinders the process? Just how does it make it that much more complicated than everything else?

Mr. ROGERS. Sure. I would love to give you an example.

So just a few days ago I was operating on a patient, and unexpectedly, the skin cancer that was on her nose extended all the way through from the outside to the inside resulting in a full thickness defect. In that sort of scenario, the reconstructive codes that are going to need to be used are, you know, extensive. And so I immediately asked my nurse, get on the phone to her Medicare Advantage plan and get prior authorization. So after an hour of being on the phone, the nurse said they are going to get back to us in a few days. But the woman, who if I do not properly reconstruct this nose, it is going to collapse. She is not going to be able to breathe properly and the cosmetics of it will be severely affected. So in that sort of scenario I go ahead and perform the reconstruction including cartilage grafting and flap reconstructions with the distinct possibility that there will be no payment on the end.

Mr. CHABOT. Thank you very much, Doctor.

Dr. Cullen, many states have recently passed laws on STEP therapy protocols that would benefit doctors, patients, and insurers. Do you think these legislative efforts can improve some of the burdens that you have described with prior authorizations?

Dr. CULLEN. I think specifically reducing the amount of time to get a response, those kind of legislations have been shown to be invaluable. I, unfortunately, have not been able to experience any of these personally because Alaska has not done either one of those as far as STEP therapy or timeliness in response. We would like to see the STEP therapy though drastically reduced as an academy because we do not see that as being a valuable way to pursue this.

Mr. CHABOT. Okay. Thank you very much, Doctor.

Dr. Walega, according to CDA data, most opioids are not prescribed by physicians such as yourself but rather primary care physicians or dentists. Are prior authorization requirements for opioids worth the extra time it takes if it helps keep addictive medications at bay?

Dr. WALEGA. First of all, I would like to mention that the number of opioid prescriptions in the United States is going down and the number of deaths related to prescribed opioids has also precipitously dropped. The deaths that we are seeing is primarily from recreational use, basically street drugs, heroin and fentanyl.

As far as the pathway of primary care physicians writing for opioids as well, I think we have made tremendous gains in educating providers, primary care providers, as well as ancillary providers with regard to not going to opioids first, and if opioids are going to be prescribed, having much more tight guidelines, practice guidelines around that. Urine drug screening on a regular basis if the prescribing will continue. Having the patient read and sign and agree to an opioid agreement which states the prescriber will be the only prescriber. The patient will take the medication as prescribed, not run out early, not double the dose, not treat themselves without the provider's input.

So that problem, I think, is decreasing. We still do see the CDC guidelines on opioid prescribing misappropriate or misapplied wherein here is a CDC rule that says do not prescribe more than X amount of drug per day to all patients, and that is misapplied. We have patients who have done very well on doses of opioids higher than that doing well, showing no use of substance use disorder. And that medication is being denied at times.

Mr. CHABOT. Thank you, Doctor. I appreciate it.

I want to get one to Dr. Harari real quickly.

Doctor, Cincinnati Children's Hospital in my congressional district helps community practices with their billing and software needs. Do you know of any other hospital systems that do this?

Dr. HARARI. There are. There certainly are. We have at the University of Wisconsin, and I am sure similar in your state, as a major academic center where we have satellite outreach clinics in community practice settings where we provide the radiation oncologists and physics technical care and we will assist them with the billing process in those community processes.

Mr. CHABOT. Thank you very much.

And I would note, Cincinnati Children's Hospital is usually in the top three best children's hospitals in the country. And when you consider the size of Cincinnati versus some other areas, we are very proud of Cincinnati Children's Hospital. So, thank you very much.

Chairwoman VELÁZQUEZ. The gentleman yields back.

And now we recognize the gentlelady from Kansas, Ms. Davids for 5 minutes.

Ms. DAVIDS. Thank you, Madam Chair.

I appreciate the opportunity for us to discuss this very important topic today. I definitely am determined to do everything I can while during my time here in Congress to increase patients' access to health care. I am very, very concerned about the prior authorization and STEP therapy being used are barriers to that access.

I have heard from a lot of providers in the Kansas Third District which I represent, providers and physicians, and they are frustrated. They are disheartened by the way that prior authorization and STEP therapy are used to delay care. And I know some similar sentiments have been shared here today.

I was recently able to take a tour of a pediatric orthopedic practice in Prairie Village, Kansas, and learned about the burden of STEP therapy in their practice. For that small business, fighting for a single STEP therapy protocol exemption or appeal costs their nursing staff sometimes 1 or 2 full hours as different insurance

providers use different and often complex processes. That kind of arduous paperwork just to provide the right care to patients imposes increased administrative costs which I am sure you are familiar with. And just the time to the medical practice.

I guess the first question I would ask is prior authorization and STEP therapy are intended to be processes that encourage providers and insurers to seek the most cost-effective treatments and procedures. Do you think those processes generally reduce out-of-pocket costs for patients? And I will just open it up because I am sure everybody on the panel probably has thoughts on that.

Dr. CULLEN. I do not think that it does. I mean, first off, I think that if we just had a transparency of what the direct costs were, the actual costs, that we would more to reduce costs for our patients than any other factor. Because as family physicians, that is what we try to do. We try to reduce the burden for our patients regardless.

What I have seen though is that the costs really have risen as we have engaged in this whole process of prior authorization and STEP therapy. And so it really does not seem to be doing its intended purpose, if that ever was its intended purpose. But like I said, I think just having a transparency of what things actually cost is going to do more than anything else.

Mr. ROGERS. From the dermatology perspective, I can tell you that in many circumstances the cost to the patient is grossly higher. And I will just use an example of what is called a topical calcineurin inhibitor, which is a type of cream that is nonsteroid and has no side effects associated with the skin. And a lot of insurers are requiring two failures of steroid medication which may be contraindicated to sensitive areas like groin, face, things like that, before you can get coverage of the medication that is going to work with the least side effects. And so the patient has multiple copays before they actually get what they need.

Dr. WALEGA. I also think there are cases in which the steps of the STEP therapy really do not make sense for the patient and it wastes valuable time and money. I think in cases, particularly with specialists, I am probably biased, but by the time the patient gets to a medical specialist, many of the simple things have failed. And our judgment I think is quite important, and in some cases we should be deferred to and we are not.

Ms. DAVIDS. Well, one, I appreciate that and Dr. Cullen, I would just say I think you hit the nail on the head when you said if it was the intended purpose.

I will leave it at that. I appreciate your time, your testimony, and the work that you all are doing.

And with that I yield back.

Chairwoman VELAZQUEZ. The gentlelady yields back.

And now we recognize the gentleman from Minnesota, Mr. Hagedorn, for 5 minutes.

Mr. HAGEDORN. Thank you, Madam Chair. Thanks to the witnesses.

I would agree. You go out and do all this education, training. Put years and years of work to prepare to treat patients and then you go to do the work and you have to ask permission every step of the way and people are looking over your back and questioning you.

And then sometimes changing basic decisions that you make as to how best to treat patients. And so whatever we can do in order to make it possible for you to do your job, we will support you 100 percent. We will support that bill you are talking about with the Safe STEP Act.

And also, but is this not also part of kind of a scam that is going on with these pharmaceutical benefit manager programs where you will prescribe a drug and there may be like two competing drugs do the same thing and when it comes time to fill it at the pharmacy there are these rebates and things that they get back the money. It does not go to the patient. It does not go to the consumer. It certainly does not go to you. And they are picking winners and losers as to which drugs to use based on basically kickbacks. They jack up the price of the drug in many instances in order to make that happen. Are you familiar with this? Do you see this in your practice? I will leave it to anybody. You do not have to use my language on it. I am pretty tough. You know what I am talking about though; right?

Mr. CULLEN. I think that I am going to defer to your expertise on this.

Mr. HAGEDORN. Well, we spent some time during the break with a local pharmacy and they walked us through it. And it is pretty rough what happens. And it is, again, it is not helping the consumer and it is not helping the patient, necessarily. But they are deciding based upon what works best for them financially which of the drugs to prescribe. And in the olden days, you know, doctors would talk with pharmaceutical company owners. Now you cannot have hardly any of those conversations. You cannot take a pen. They have wiped you out of that, which is fine, I guess. But there is this kind of middle man that is doing that job now and I would like to see some of the reforms. If you do not want to address it, maybe it is too sensitive. But we will move on from there.

The other thing I would say is this is not just a problem that you have with private insurance companies; right? Do you not deal with the government a little bit and have some of the same issues? Like, there are some things that we can do to streamline that with Medicare, Medicaid? I will start over here.

Dr. HARARI. Absolutely. This is pervasive, and I think your words that this is not benefitting the patient is very precious. There is no benefit to a cancer patient to have a delay in the start of their treatment. And even when there is the intent to be sure that an effective therapy is being delivered often by pushing the physician to generate a less expensive therapy that comes with collateral damage in the name of radiation, we are applying a simple plan to treat a brain tumor where the beam has to go through the eye and cause damage to normal tissue or go through the heart to treat a lung cancer because they want to see a simple, just front and back radiation rather than a conformal plan. Less expensive but more damage to the normal tissue for the patient. And so in terms of cost, ultimately this costs the healthcare house of medicine much more to deal with those side effects. So this happens on all sides.

Dr. WALEGA. On a more practical level I know that my Medicaid patients and the Medicare Advantage patients are scheduled

15 business days after their evaluation with me when I have put forth a treatment plan because we know it is going to take at least that long to get that approved. So 15 business days is 3 weeks. That is a long time to wait for treatment when you have pain that is described as 10 out of 10.

Dr. CULLEN. We actually have fewer problems with Medicaid and Medicare than with a lot of the private insurers. I mean, this is a process that is going across the board but I guess in answer to your previous comment, the big problem we are having is that the formularies are changing on a regular basis and that is because of things other than patient care. And so that is something that we are dealing with. It is creating just tremendous chaos in our ability to prescribe for our patients. And it is causing chaos for the patients because a lot of times they have been on medications for years and all of a sudden we have to come up with something else. And even if we change the dosage, we have to come up with another prior authorization plan. This has absolutely gotten out of control. So in light of that, actually, the Medicaid and Medicare are actually doing better than the others.

Mr. ROGERS. Congressman, I agree with you entirely in that government plans are a problem in addition to private insurers. At least in my state, the kind of most egregious delays in care and not getting back to our office of whether a prescription is approved or denied is frequently seen with the state Medicaid.

Mr. HAGEDORN. Thank you very much.

Chair, thank you.

Chairwoman VELÁZQUEZ. The gentleman yields back.

And now we recognize the gentleman from Pennsylvania, Vice Chair of the Committee, Mr. Evans.

Mr. EVANS. Thank you, Madam Chair. I thank you, Madam Chair, and the Ranking Member for this hearing. This is very appropriate during this time.

Dr. Cullen, according to your testimony, primary care physicians spend nearly 50 percent of their time on administrative activities, such as prior authorization and only 20 percent of their time on clinical activities. Do these burdensome tasks limit the number of patients primary care physicians can accept and treat?

Dr. CULLEN. Indeed. So I have been in practice for 25 years. Before all this started I would see about 25 patients a day. I am now down to about 15 patients a day. So this has reduced the number of patients that I have been seeing. That is a problem because we are looking at a severe shortage of primary care physicians in this country, and what I am experiencing is being replicated across the country.

Mr. EVANS. Can you explain the role in that particular case of primary care or family physicians in the patient's overall health care?

Dr. CULLEN. So one of the reasons why our healthcare system is as expensive as it is, is that we do not prioritize primary care to the extent that we should. We are spending about 4 percent of our dollars on primary care. Other healthcare systems that are spending a lot less money on health care than we are have upwards of 15 to 20 percent of their dollars spent on primary care. The problem is, is that things that are not caught in a timely fash-

ion or the chronic diseases that end up in hospitalizations, if we do not have family physicians and primary care physicians managing those, you end up spending a lot more money. So for every dollar spent on especially advanced primary care, you save about \$13 overall to the healthcare system as a whole.

One of the reasons why we are spending as much as we are, 18 percent of our GDP on health care is because we are not prioritizing primary care.

Mr. EVANS. Can anyone else on the panel, that same question I asked, explain the role of primary care family physicians and patient, give some reaction to that? Any other comments on that?

Yes?

Mr. ROGERS. I agree with the incredible importance of having ready access to primary care with a huge variety of different treatments that they can do in disease processes. As a small specialist, I also see the value of specialty care in that there are more advances in medicine every year than has ever been in the past of medicine. And so in order to provide patients with the most up-to-date care, we need an integrated system that allows primary and specialty care to interact and collaborate efficiently.

Dr. WALEGA. I would also add that we have discussed the shortage of primary care physicians. That trend is continuing. When medical students finish medical school and they go through their training, they often have \$100,000, \$200,000, \$300,000 worth of debt. I cannot imagine that one would be able to pay off that debt in a timely way if you are seeing 12 to 15 patients a day in a family practice. It just does not make any economic sense at all. So that trend will continue.

Dr. HARARI. There is a reason that many of the U.S. medical schools are emphasizing primary care to their medical students. At the University of Wisconsin, we are one of two schools of medicine and public health that is trying to serve the needs of the state in rural areas of Wisconsin. Many states have this issue where the cities are well served with primary care but the rural communities are not. And so as Dr. Cullen alluded to, we have to make a much more concerted effort to provide talented primary care providers to our citizens.

Mr. EVANS. Madam Chair, I yield back the balance of my time.

Chairwoman VELAZQUEZ. The gentleman yields back.

And now we recognize the gentleman from Pennsylvania, Dr. Joyce, Ranking Member of the Subcommittee on Rural Development, Agriculture, Entrepreneurship, and Trade for 5 minutes.

Mr. JOYCE. Thank you, Madam Chairwoman.

Today, I have with me a letter signed by 371 national and state-based patient, provider, and other healthcare stakeholder groups in support of H.R. 3107, the Improving Seniors Timely Access to Care Act, which would bring the needed transparency and accountability to prior authorization in the Medicare Advantage Program. I respectfully ask that the letter be submitted for the record.

Chairwoman VELAZQUEZ. Without objection, so ordered.

Mr. JOYCE. Thank you, Madam Chair.

First of all, I look out at this esteemed group, and with bias I say it is the most intelligent group that has presented to our Committee so far.

Mr. CHABOT. We have got a lot of intelligent people here.

Mr. JOYCE. Thank you, Ranking Member Mr. Chabot.

I have worked closely with radiation oncologists, I have friends, I have utilized anesthesiologists with backgrounds in pain management. And daily, until just 8 months ago, I would interact with family practitioners who are the heart and soul of American medical care. And of course, when I look at Dr. Rogers, I see a compadre, a board-certified dermatologist, a fellow in the American Academy of Dermatology. We share so much. I hear your story and I thank each and every one of you for bringing it to the halls of Congress. It is so important for us to realize what you go through on a daily basis for as you said, Dr. Cullen, to make people's lives better. It seems like a simple goal. And yet there are obstacles that are being placed in front of you. And we need to hear and work hard to repair those obstacles that are in front of you.

So please allow me, if I can address the first question to Dr. Rogers for being here today.

Dr. Rogers has an interesting expertise that I would like to illuminate and tell everyone on the Committee what he does. He is a board-certified dermatologist, as he said, that takes care of over 3,000 diseases, skin diseases, and diseases that affect all organ systems in the body. In addition to that, he did additional training in Cincinnati with Dr. Brett Coldiron in Mohs micrographic surgery which is a long name for a type of surgical training that allows the dermatologist to remove the skin cancer and see that the margins are clear and then repair it. So it seems like a simple process. He talked about treating a patient with a skin cancer on their nose and arduously he removed that skin cancer until there was no sign of it left behind and then he went to repair that and he could not have the authorization to do that repair. This is a tragedy. This does not allow for good patient care.

So what does that mean? That means that the patient is going to have to come back, risk adverse reactions, the collapse of the cartilage of their nose while he waits for the approval to do that, and go through anesthesia again. Go through the injections that he has already put the patient through and is prepared to repair that.

Dr. Rogers, did I summarize this case clearly?

Mr. ROGERS. You did. Thank you, Congressman. You did summarize that well.

As a dermatologic surgeon, it is clear to us that as we are working on the patient, there are a lot of patient-specific factors. We cannot know exactly how best to repair somebody from a functional standpoint so that they are going to breathe, have normal lip function, have normal eyelid function, as well as a great cosmetic result beforehand, which is basically what the insurer is asking for. They are asking for a prior authorization exactly how this is going to go. And when you are in the operating room, you do not know until you are there and then you are scrambling to try to get prior authorization to do a medically necessary procedure to put this patient back together.

Mr. JOYCE. In other areas, let's talk general dermatology if I may, please.

Someone comes into your office. They have a cellulitis, a skin infection of the upper extremity. And let's say from our common

knowledge base that you prescribe a form of penicillin, maybe a cephalosporin that has been in the generic form since I graduated from medical school, from a long time ago. And you want to prescribe Cephalexin. What obstacles are placed in front of you, Dr. Rogers?

Mr. ROGERS. Yeah. So this has actually become a problem this year which is just kind of unimaginable. So the main standard of care treatment for a staph infection, superficial staph infection, is oral Cephalexin. We all know if you have a staph infection you have got to jump on it right away. And there is an insurer who has placed a prior authorization on Cephalexin, and I have seen two instances in my office where superficial infections have gotten out of control because of a prior authorization process that delayed treatment. The patient went to the pharmacy, did not get their medicine, and then progressed rapidly and had to be hospitalized resulting in hundreds of thousands of dollars of expense that could have been dealt with right at the pharmacy.

Chairwoman VELAZQUEZ. The gentleman's time has expired.

I now recognize the gentlelady from Minnesota, Ms. Craig, for 5 minutes.

Ms. CRAIG. Thank you so much, Madam Chairwoman.

I just want to start by saying I had an ear infection last week and I went to see my primary care physician and I got an earful pretty much in addition to treatment for that ear infection on exactly what each of you have testified this morning. So thank you so much for being here.

Health care is absolutely the number one issue that I hear about in my congressional district. My colleague from Minnesota just a moment ago talked about the cost of prescription drugs. My own experience in health care has been that when we have these conversations it is a little bit like the circling firing squad. Brand name pharmaceuticals blame the PBMs. PBMs blame the pharmaceutical companies. And everybody blames the health insurance companies.

I am curious as we sit here today on a couple of issues though. Where do you think each of you, as members of Congress, we can beyond just the administrative burden which is absolutely clear is an issue in our country, where else would you have those of us who just arrived in Congress focus in terms of the cost of health care? Not just the cost of health insurance but the cost of health care?

And I was particularly curious, Dr. Cullen, your comments around prevention over care. And then I want to ask the specialists a couple of questions, too.

Dr. CULLEN. So a lot of it I think has to do with access. And how much people are paying out of pocket, which is definitely getting worse.

I had a patient recently who did not come in to be seen for an ear infection because of her copay. As a result she developed just a rip-roaring otitis externa that I ended up having to put her in the hospital for. So what would have been a \$65 visit and a \$25 prescription of an antibiotic turned into probably a \$15,000 to \$20,000 hospitalization. We are doing this repeatedly where we are saving money up front and we are paying so much more down the road. And that is not only true with just the cost. I mean, there

is a human cost, too, because, for example, maternal mortality has increased and part of that has to do with the access for prenatal care which is diminishing and we are having obstetrical deserts develop in the country. Access is probably one of our biggest things. Because we do not have that access, and I would include the access to a primary care physician, that we are spending enormous amounts of money at the other end where we could be spending a little bit in the beginning and we could be recouping that investment enormously at the other end. I think that is probably the biggest issue outside of the amount of administrative work.

Right now we are spending, yes, it is two for one, 2 hours of administrative time for every hour of patient care. If we cut that in half we could see twice as many patients. I mean, this is something we definitely need to address.

Ms. CRAIG. I also just want to follow up with that with Dr. Harari.

Tell me, is there any reason in your mind to justify prior authorization for CT scans when dealing with routine cancer care? It is interesting to me that that is even a barrier for you.

Dr. HARARI. It is interesting to us as well. I recognize that in the broad scale of medicine, imaging can benefit from care and judicious allocation of resources. But when a patient has a cancer diagnosis and they need to have high quality imaging, be that a PET scan or a CT scan to best, most accurately define their tumor so that a surgery or radiation or chemotherapy can be most effectively delivered, it is unfortunate sometimes to have so much second guessing of the known cancer expertise on what that imaging should be.

Ms. CRAIG. And where would you have us focus on driving down the cost of health care?

Dr. HARARI. You mentioned, the others have mentioned the issue of prevention. Cancer prevention is an enormous area of potential benefit. The funding of the National Cancer Institute and the NIH in advancing prevention studies, the known role of tobacco and alcohol and nutritional elements that contribute to cancer, we could diminish the cancer burden in the U.S. dramatically with some steps in those areas as opposed to waiting until there is an advanced cancer present.

Ms. CRAIG. Thank you.

Madam Chair, I am just about out of time, so I will yield back.

Chairwoman VELAZQUEZ. The gentlelady yields back.

And now we recognize the gentleman from Oklahoma, Mr. HERN, Ranking Member of the Subcommittee on Economic Growth, Tax, and Capital Access for 5 minutes.

Mr. HERN. Thank you, Madam Chairwoman, Ranking Member, and certainly to the docs that are here to testify on real problems in medicine today.

Like my colleague said, no matter where you go, you do not have to be a doctor, you can be a patient. If they know you are in Congress, you are going to hear the issues. And so it is great to hear it firsthand.

I have been a businessman for 34 years, and what we know is regulations cause problems. Certainly, when you have extraneous regulations like you all are experiencing, it is very difficult. In my

world, it is Dodd-Frank and many other regulations that cause a real burden on the small business. We have heard these from many times over and people sitting in your same position. As the Ranking Member said, we have had a lot of really smart people talking about regulation, regulatory problems across many industries.

You know, in the small business practices, your hurdles really are about utilization management programs that are all sizes that really create a real problem. It could be as much as pharmaceutical companies advertising on TV a better drug than you prescribe. And the patient saying I want that drug because I saw an advertisement. We have a whole plethora of issues that we need to get after in this realm. As my colleague once again said, this is one of the number one issues, if not the number one issue in America today to figure this out.

Fortunately for me personally, I have a colleague that is a dear, dear friend of mine that you have already heard from that I want to yield the balance of my time. I am a person that says instead of some of us that just talk about and use talking points, let's let folks who are really experts in this field, and I want to yield the balance of my time to Dr. Joyce, please.

Mr. JOYCE. Thank you, Representative Hern. And thank you, Madam Chair, for allowing me just to complete this.

I think the message that you brought to us today is clear. That STEP therapies and authorizations delay care. So I am going to allow Dr. Rogers just to kind of shine the light on what you mentioned briefly. But I am going to lay some background.

So he talked about treating some serious skin conditions and the ability to make a decision not to use topical steroids, which have severe side effects in some situations of where you apply them. So you might not want to put a topical steroid on your face because it thins the skin. And there are other areas of the body that you might choose to use a prescription Vitamin D analog. He mentioned it by its name.

And yet, Dr. Rogers, I am going to turn it back to you with the remaining time. So I send to you a 12-year-old with a type of dermatitis, an inflammation of the skin that you make a decision to use a nonsteroid, a topical therapy that has very few side effects to the skin that is a Vitamin D analog. What challenges do you face?

Mr. ROGERS. So for dermatology, pediatric patients are, they are special. They have a very high amount of surface area of skin, and so you always have to worry about side effects and absorption in those patients. And so you do not necessarily go through the standard way of thinking about patients. You start with safety first because that is how I would deal with my own children.

And so when I see a patient like this, first of all, I know that I am in for a long, lengthy battle. It is not the old days where you write a prescription, send them to the pharmacy, and they get what you prescribe and get better. So I come out of the exam room and I say, all right, we are going to start this Vitamin D analog. Could you start the process? And so the prescription gets entered and the pharmacy then gets a denial. And then they send back a number for us to call of the pharmacy benefit manager that is associated with this insurance. And then my staff spends an hour on the phone to figure out what clinical information it is that they

want. Then we get some forms, fill those out, send it back. Then, they send it back saying denied. You need to go through STEP therapy. I write an appeal letter saying this is a 12-year-old boy. I do not want to be placing a high-potency topical steroids that are going to result in side effects in this patient. It is not standard of care. They delay for 2 weeks and then it results in a denial. I write another appeal letter and get a peer-to-peer which may or may not go through. The whole process took me an hour and it took my staff 4 hours for this denial. And the frustration level is quite extreme.

Mr. JOYCE. And in the meantime, the patient care is delayed; is that true?

Mr. ROGERS. Delayed and the patient continues to suffer needlessly.

Mr. JOYCE. I think that you have all come to us to shine a light on this problem, and I thank my colleague for the additional time. Madam Chair, I yield back.

Chairwoman VELAZQUEZ. Thank you. The gentleman yields back.

Now we recognize the gentleman from Illinois, Mr. Schneider, for 5 minutes.

Mr. SCHNEIDER. Thank you, Madam Chairman. And I want to thank the witnesses.

I apologize. We are oftentimes pulled in different directions, so I am just getting here. But I had a chance to read through your testimonies, so I appreciate you sharing your experiences.

Dr. Walega, I will start with you. Also from Chicago. Been a patient at Northwestern. A fan of Northwestern. Graduate of Northwestern.

But in your testimony you described the testimony of a 38-year-old patient who goes through a process. You do the first step of the test to make sure the treatment works and then you have to go through the delays. And I read that story with empathy, frustrations. You can run through the list of emotions.

What would the right process look like if you were just to describe it? What are the goals that we should be working to achieve in putting guardrails on the system but making sure that you are able to do what you want to do and that the patient is able to get, in this case, the woman is able to get the treatment that she deserves?

Dr. WALEGA. So I know the case was fairly extreme but I actually experience these same similar stories every day.

I think the main point of this case was a tremendous delay between when we found a proven therapy that improved profoundly this patient's quality of life, her family's quality of life beyond expectations, 8-1/2 months later requiring, you know, going back on opioids, I think everyone in this room has been concerned about the opioid crisis. The pendulum is swinging on opioid prescribing. We do not ever want to put a patient back on opioids if we found something better, more effective, that can be used for the patient's entire life. A shorter period between the time of the proposed therapy and the actual approval. We need to have a specialist who is similarly trained or experienced to help make the decision whether the treatment that we are proposing is medically necessary. Our role

should not be to educate someone who knows absolutely nothing about the therapy or the disease process. That individual should not be in charge of deciding the patient's healthcare fate.

Mr. SCHNEIDER. And to that point, Dr. Harari, and I may be repeating myself of things said earlier, but in your written testimony you talked about the times that you are talking to someone who is not a peer-to-peer review. And you know, if you can elaborate on that. Is it absolutely necessary to have someone who is a peer or just have someone who understand what you are talking about? Is that trainable?

Dr. HARARI. Thank you, Congressman. Ultimately, we want to have someone who has the best interest of cancer patients in mind. And repeatedly, it is apparent that that is not necessarily the case when we are going through the prior authorization process. There does appear to be a repeated denial and delay strategy knowing that some practitioners, particularly small, private community practitioners who do not have the bandwidth to hire personnel to combat the paperwork with prior authorization. We have had ASTRO members recount stories where they say I will go ahead and deliver the slightly less optimal radiation treatment plan knowing that then I will not have to go through a 5-hour process or recreate multiple treatment plans that are going to be denied. So ultimately, that is hurting cancer patient outcome and ultimately adding cost to the system.

Mr. SCHNEIDER. Okay. And my last question I will ask the whole panel and start with you, Dr. Rogers and go across.

I understand the problems with process, and I come to this as an industrial engineer, process engineer, process matters. What about the goals of trying to make sure, not just that we are getting the right care but the right cost? Is there a problem with the goals at the very beginning or is this strictly the process?

Mr. ROGERS. In a time of increasing healthcare expenditures, of course the goal has to be to deliver cost-effective, high-quality care. Having a prior authorization process that is efficient, transparent, and workable for a small business practice would meet that goal plus the goals of running a small business.

Mr. SCHNEIDER. Dr. Cullen?

Dr. CULLEN. And I would agree with the goal is we want high quality but a less costly system than we have currently.

As far as the process, we have all gone through training for many, many years and I think that one of the frustrations about this is the not trusting us to use our best judgment based on our education and based on our experience. We could save enormous amounts of money by just not engaging in all this activity. So I think we need to minimize the prior authorization process as much as possible.

So I have two people that are doing full time. They are doing prior authorization. They could be better served taking care of patients, doing prevention, doing education. Instead, all of our resources are really devoted to something that we have the training just to take care of.

Mr. SCHNEIDER. And I am out of time.

Chairwoman VELAZQUEZ. The gentleman's time has expired.

Mr. SCHNEIDER. I yield back.

Chairwoman VELÁZQUEZ. Now we recognize the gentleman from Ohio, Mr. Balderson, for 5 minutes, who is the Ranking Member of the Subcommittee on Innovation and Workforce Development.

Mr. BALDERSON. Thank you, Madam Chair. And thank you all, panel. I appreciate you all taking the time to be here today.

I am going to be very brief. I know that everybody has been here for quite some time. But last year, physicians, pharmacists, medical groups, hospitals, and health insurance announced their commitment to working together to improve prior authorization process for patients' medical treatments. I have a consensus here, and I would like to put this in the record, please, that was done by many member organizations that most of you are associated with. And if you do not know what this is, I can most certainly give it to you. We can send you guys a copy so you can go over this. AMA authorized it. Blue Cross Blue Shield, American Hospital Association, amongst some of the few.

But in it, the healthcare leaders stated their intent to work together to streamline requirements for therapies, as well as accelerate industry adoption of national electronic standards for prior authorization.

What other actions could be taken to improve the challenges faced by healthcare professionals? And anybody on the panel can answer the question.

Dr. Harari?

Dr. HARARI. Thank you, Congressman, for bringing that forward. And the comment, there are a lot of elements of the prior authorization that could be streamlined and improved. There are centers of excellence in terms of quality and value that are having 90 percent of their denied prior authorizations overturned on appeal. Those centers could be identified to say there is no practice challenge here. We could spot check 1 in 10 cases for prior authorization rather than torture them through every case. There are a variety of examples like that. Increased transparency, publication, public dissemination of the utilization parameters that each insurance provider uses so that it is not a mystery to the patient and to the provider as to which regulations they are using. Often, they are not using national standards. In oncology, National Comprehensive Cancer Network, 30 of the top cancer centers in the Nation that create guidelines, many of these third-party benefit manager organizations do not even adhere to those national benchmarks. So there are a number of areas of transparency that could be improved.

Mr. BALDERSON. Thank you. That was a great answer.

Would anybody else like to comment?

Doctor Rogers, I apologize.

Mr. ROGERS. Thank you very much for that excellent question.

One of the things that comes to me that could definitely improve the situation from a transparency standpoint and also from a consistency standpoint would be to have, instead of pharmacy benefit managers deciding on how best to administer prior authorizations, have the physicians who are at the point of the spear weigh in. You know, the American Academy of Dermatology would love to have a seat at the table in terms of defining what is reasonable in terms

of different treatment algorithms and would have much greater buy-in from our physicians if we could have that sort of collaborative arrangement.

Mr. BALDERSON. We are dealing with PPMs in the state of Ohio I am sure you have heard.

Dr. CULLEN. So I think, I told the story earlier that I had to prior authorize hydrochlorothiazide which is a generic medication. I think that all generics should not have to go through the prior authorization process. I think that is just absolutely ridiculous. And so I think that as much as we can minimize that prior authorization I think is really important.

As physicians, we really do try to do the right thing by our patients and we are spending a lot of money just because there are a few outliers. And I think that all of us are trying to do the very best we can for our patients for the least amount of cost. And I think there needs to be some recognition that that is what we are trying to do. Part of the problem with prior authorization is assuming that physicians are only in it for other reasons and that is just not the way it really is. And so I think that I would like to see all of that whole process minimized.

For those practices that are involved in quality-based payment contracts, there is really no reason to have prior authorization at all. And that is with alternative payment methodologies. Not fee-for-service. We were actually getting paid by the quality we deliver. And so there should be no prior authorization for those practices.

Mr. BALDERSON. Would you like to add or do you think that everybody has fulfilled the—

Thank you very much. And I appreciate it.

I yield back, Madam Chair.

Chairwoman VELÁZQUEZ. The gentleman yields back.

Let me take this opportunity again to thank all of the witnesses for taking time out of their schedule to be here with us today.

As we have heard today, our country's healthcare providers want nothing more than to provide their patients with the highest quality and clinically appropriate care. However, time and time again, delays in treatment are leading to adverse outcomes by taking doctors away from patient care. We need to improve the prior authorization process by streamlining and standardizing some of the procedures, while also making sure there is a clear understanding by doctors and patients of the items and services subject to prior authorization.

I look forward to working with my colleagues on both sides of the aisle on this important issue. And believe me, this is a committee that works in a bipartisan way.

I ask unanimous consent that members have 5 legislative days to submit statements and supporting materials for the record.

Without objection, so ordered.

If there is no further business to come before the committee, we are adjourned. Thank you.

[Whereupon, at 12:59 p.m., the Committee was adjourned.]

A P P E N D I X

U.S. House of Representatives

Committee on Small Business

Hearing titled, "Utilization Management: Barriers to Care and Burdens on Small Medical Practice"

Testimony of:

Paul M. Harari, MD, FASTRO

Chairman, American Society for Radiation Oncology (ASTRO)

September 11, 2019

The American Society for Radiation Oncology (ASTRO) represents more than 10,000 members who strive to give cancer patients the best possible care and to advance the science of oncology. ASTRO's membership includes radiation oncologists, nurses, cancer biologists, medical physicists, and other health care professionals who specialize in treating patients with radiation therapy. Our members work in various clinical settings including hospitals, freestanding community-based radiation oncology centers, and academic research institutes. Together, they make up the radiation therapy treatment teams that are critical in the fight against cancer. Of the estimated 1.76 million people diagnosed with cancer each year, ASTRO's medical professionals treat more than one million of them, as approximately 60 percent of all cancer patients receive some form of radiation therapy as part of their treatment. As the leading organization in radiation oncology, ASTRO is dedicated to improving patient care through professional education and training, support for clinical practice guidelines, the advancement of research, patient education, and advocacy.

Radiation Therapy

Radiation therapy, or radiotherapy, is the use of ionizing radiation to treat cancer and certain other diseases. Radiation therapy is proven to be safe and effective across a broad spectrum of cancer types. Radiation therapy works by disrupting the genetic material that drives cancer cells to grow and spread. When these damaged cancer cells die, the body's natural healing processes remove them. Normal tissues are also affected by radiation, but they are able to repair themselves in ways that cancer cells cannot. Radiation therapy has many benefits, including allowing patients to maintain their quality of life during treatment. Nearly all radiation therapy treatments are delivered as out-patient procedures.

Modern cancer care requires the coordination of multiple cancer disciplines and specialists who contribute to the overall care and well-being of the patient. For each patient, radiation oncologists develop and operationalize a multi-step, customized plan to deliver radiation exclusively to the tumor-

bearing area while protecting the surrounding normal tissue to the maximum extent possible. Radiation therapy is delivered in several ways: externally, internally, and through surface application. During external beam radiation therapy, the radiation oncology team uses a machine to direct high-energy x-rays or particle beams toward the cancer. Internal or surface radiation therapy, also called brachytherapy, involves placing radioactive material (i.e., radioactive seeds) inside the patient or on the surface of their body. Depending on patient-specific considerations, the total radiation dose prescribed for the patient may be given in one session or over the course of multiple sessions. Systemic therapies, such as chemotherapy or immunotherapy, are often combined with radiation therapy to provide synergistic benefits for patients with certain types of cancer. In some cases, radiation therapy is used as the only treatment modality and is directed locally to the tumor, and in other cases it is given pre- or post-surgery to maximize the chance of the complete eradication of a primary tumor.

Investments in Radiation Oncology Care

ASTRO's membership is committed to putting patients first by delivering high-quality cancer care. Radiation oncology centers differ from most other specialty centers in that they have extremely high fixed costs. The minimum total capital required to build a freestanding radiation oncology center is approximately \$5.5 million. These facilities require an additional minimum \$2 million in annual operating and personnel expenses. A linear accelerator is the primary machine used to provide radiation treatment, and it stands about nine feet tall and 15 feet long and weighs more than nine tons. The machine must be housed in a specially shielded room with thick concrete walls. As a result, millions of dollars are needed to install the basic machinery before the first patient is seen built. This substantial upfront capital investment, combined with required machine maintenance contracts and salaries for highly skilled technical staff, means that fixed costs in radiation oncology are significant. Like all businesses, radiation oncology practices need to meet their regular financial obligations to keep their

doors open, which is why the increasingly restrictive coverage policies and benefit managers' "denial-by-delay" tactics must be addressed to protect patient access to life-saving cancer care.

Prior Authorization Negatively Impacts Cancer Patient Outcomes

Prior authorization requires physicians to obtain approval from health insurance companies to prescribe a specific treatment, procedure, or medication for their patients. Prior authorization is intended to minimize health care costs, but this is often done at the expense of a patient's well-being. When prior authorization is required, insurance companies will only pay physicians if the medical care has been pre-approved by the insurance company or a benefit manager.

Nationwide, physicians and their patients are bearing the brunt of excessive prior authorization practices. In September 2018, the Office of the Inspector General (OIG) released a report on Medicare Advantage Organization (MAO) appeal outcomes. The OIG found that many MAO denials were overturned upon appeal.

"The high number of overturned denials raises concerns that some Medicare Advantage beneficiaries and providers were initially denied services and payments that should have been provided. MAOs may have an incentive to deny preauthorization of services for beneficiaries, and payments to providers, in order to increase profits."¹

In an ASTRO survey of radiation oncologists, longer treatment delays due to prior authorization for Medicare Advantage plans were reported versus private payers. The payment delays and outright denials have created immense instability throughout the field, specifically jeopardizing the continued viability of these free-standing centers and patient access to the high-level care the centers provide.

¹ U.S. Government Accountability Office, Office of the Inspector General. 25 September 2018. *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*. OEI-09-16-00410. <https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf>.

The purpose of prior authorization is to ensure patients receive the appropriate and most efficacious treatment for their conditions. When equivalent treatment options are available, prior authorization should ensure patients are treated in the most efficient way possible, thus preventing overutilization of medical services.

Radiation oncologists and cancer patients have been particularly hard hit by prior authorization's unnecessary burdens and interference in care decisions. In ASTRO's 2018 annual member survey, radiation oncologists named prior authorization as the greatest challenge facing the field. To determine the extent of the burden on patients treated by these physicians, ASTRO launched an additional nationwide survey of radiation oncologists in late 2018. An online survey was sent to all 3,882 radiation oncologists in ASTRO's member database, which includes 86% of board-certified radiation oncologists in the United States. Six hundred twenty physicians completed the survey via email. One email reminder was sent in January 2019, and the survey closed in February 2019. ASTRO staff also administered paper surveys at the ASTRO Annual Meeting in October 2018 and collected 53 responses for a combined total of 673 radiation oncologist responses.

The findings from ASTRO's physician survey align with recent reports from the American Medical Association (AMA)² and American Cancer Society Cancer Action Network (ACS CAN),³ demonstrating the pervasiveness of prior authorization obstacles throughout the American health care system. Restrictive prior authorization practices cause unnecessary delays and interfere in care decisions for cancer patients.

² Robeznieks, Andis. "1 in 4 doctors say prior authorization has led to a serious adverse event." *American Medical Association, Sustainability*. 5 February 2019. <https://www.ama-assn.org/practice-management/sustainability/1-4-doctors-say-prior-authorization-has-led-serious-adverse>.

³ Harrington, Elizabeth. Campbell, Jay. "Key highlights from national surveys of cancer patients/caregivers and physicians who treat cancer patients." *American Cancer Society Cancer Action Network*. 12 March 2019. <https://www.fightcancer.org/sites/default/files/National%20Documents/ACS%20CAN%20UM%20Survey%20Key%20Findings%203.28.19%20FINAL.pdf>.

Nearly all radiation oncologists (93%) surveyed said their patients face delays in receiving life-saving treatments, and a third (31%) said the average delay lasts longer than five days – a full week of standard radiation treatments. These findings are cause for alarm given research linking each week of delay in starting cancer therapy with a 1.2% to 3.2% increased risk of death.⁴ In addition to treatment delays, prior authorization adds stress to patients already concerned about their health. One survey respondent shared:

“For many of my patients the prior authorization process adds significant stress and concerns over financial liabilities associated with treatment. When an initial submission is denied or delayed, and a peer-to-peer consultation is requested, this adds to the stress level. In these increasingly frequent instances, the authorization is not obtained for several days and can even exceed a week. Denials for a particular service are most traumatic experiences and I had several patients break down in tears fearing that they would now have to receive an inferior treatment.”

More than seven in 10 radiation oncologists (73%) surveyed said their patients regularly express concern about the delay caused by prior authorization, and 32% of radiation oncologists were forced to use a different therapy for a substantial number of their patients due to prior authorization delays. One radiation oncologist illustrated the negative effects the prior authorization process had on his patient, saying:

“In some situations, patients with severe acute problems such as obstructive tumors [or] painful tumors, rapid review still is multiple days. Certainly, this can lead to patients not overcoming a severe situation and [instead] dying from it. However, in addition, this can leave patients with

⁴ Khorana AA, Tullio K, Elson P, et al. Time to initial cancer treatment in the United States and association with survival over time: An observational study [published correction appears in *PLoS One*. 2019 Apr 4;14(4): e0215108]. *PLoS One*. 2019;14(3): e0213209. Published 2019 Mar 1. doi:10.1371/journal.pone.0213209.

very severe symptoms while waiting for their treatment authorization to occur. The system is made to put off treatment for days at a time, which is very unfortunate. It is not right, it is inhumane.”

Physicians also detailed many frustrations that reveal a broken prior authorization peer-review process. Many vented frustrations about an inability to get in touch with their peer-reviewer and peer-reviewers who took several days, or even weeks, to respond to requests.

More than four in 10 respondents (44%) said their peer-reviews typically are not conducted by a licensed radiation oncologist. Only a radiation oncologist has the proper training to determine if a radiation treatment is appropriate for the patient. As one survey respondent explained,

“Patients have experienced financial toxicity as treatments have been initiated [with] approval only to retroactively be rejected. Most frustrating is ‘peer-to-peer’ by non-radiation oncologists who simply state, ‘The policy is to reject this,’ with no ability to discuss the clinical case or provide medical judgement — not a fair representation of what ‘peer-to-peer’ should be.”

Radiation oncologists increasingly are restricted from exercising their clinical judgment in determining what is in the best interest of their patients, yet they are held accountable for treatment outcomes even in situations when care decisions have been taken out of their hands by peer-reviewers.

Prior Authorization Takes Physicians Away from Caring for Their Patients

Nearly one in five radiation oncologists (17%) surveyed said they lose more than 10% of the time they could be caring for their patients on dealing with prior authorization. An additional 39% spend 5-10% of their average workday on prior authorization. More than 4 in ten radiation oncologists (44%) need prior authorization for at least half of their treatment recommendations. An additional third (37%) need it for at least a quarter of their cases. Eighty-five percent of respondents said that radiation

oncology benefit management companies (ROBMs), who perform prior authorization duties for insurance payers, required them to generate multiple treatment plans, which require physicians and medical physicists to spend several hours developing alternatives to their recommended course of treatment. While perhaps intended to reduce administrative burden, prior authorization instead increases burden. In fact, many radiation oncologists (63%) had to hire additional staff in the last year to manage the prior authorization process.

Many prior authorization practices are merely unnecessary delay tactics insurance payers use to deter physicians. This is illustrated by the fact that nearly two-thirds of radiation oncologists (62%) surveyed said most denials they receive from prior authorization review are overturned on appeal. These numbers are not consistent with the premise that prior authorization methods are being performed to protect patients and prevent overutilization of services. Rather, the high number of overturned denials raises concerns that some Medicare Advantage beneficiaries and providers were initially denied services and payments that should have been provided.

Patients at Community-based Clinics Face Disproportionate Burden from Prior Authorization

The majority of cancer patients receive care from private practitioners in community-based settings, and this is where the burden of prior authorization is especially pronounced. Patients treated at community-based, private practices experience longer delays than those seen at academic centers. For example, according to the survey, average treatment delays lasting longer than a week were reported by 34% of private practitioners versus 28% of academic physicians. Radiation oncologists in private practice are almost twice as likely to spend more than 10% of their day focused on prior authorization, compared to physicians at academic centers (23% versus 13%). These practices often have less staff to handle increased prior authorization requests, and radiation oncologists are forced to spend time on

prior authorization paperwork that they could better spend on patient care. One radiation oncologist in private practice reported:

“The added anxiety from the letter that cancer patients receive from their health plan explaining that the care plan we submitted is not standard, or not approved according to their guidelines is absolutely unnecessary, since most times it gets approved on appeal. [This is] detrimental to patients already overwhelmingly anxious about life and death and undermines the sacrosanct doctor-patient relationship. This requires undue extraordinary reassurance and valuable time on our part.”

Conclusion

Prior authorization is meant to ensure patients receive the appropriate and most efficacious treatment for their conditions, in the most efficient way possible. ASTRO’s survey findings clearly show that current prior authorization practices do not meet these goals. If left unchecked, these methods will lead to increased financial toxicity and worse outcomes for cancer patients, as well as increased administrative burden for physicians.

The prior authorization process must be a productive use of physician and patient time, instead of a delay tactic that often results in no change of treatment. While an equivalence of choices can be difficult to establish, physician judgment for individual case circumstances cannot be indiscriminately infringed upon. Radiation oncology and cancer patients have been particularly hard hit by this unnecessary burden and interference in care decisions. Congress must put an end to restrictive prior authorization practices, particularly those employed by Radiation Oncology Benefit Managers (ROBMs), that oversimplify the process of individual patient care management and abrogate the professional and personal judgments of physicians and patients.

The following response from ASTRO's survey summarizes the negative impact prior authorization has on patients:

"Prior authorization can be extremely negative from the psychological point of view. Patients are very anxious to get [treatment] started, and some have even had panic attacks during this process. It places stress on [radiation oncologists] to get multiple plans done quickly – rushing an already complicated process. There is no transparency or effective way to expedite treatment."

The Improving Seniors' Timely Access to Care Act takes crucial steps to require accountability from insurance payers and benefit management companies by streamlining and standardizing prior authorization under the Medicare Advantage program and providing much-needed oversight and transparency of health insurance for America's seniors. Members of this body can put themselves in the shoes of a newly diagnosed cancer patient to appreciate the significantly negative impact that treatment delays have on their lives. Cancer patients deserve to be able to focus on their medical care and opportunity for cure. ASTRO appreciates Congress' longstanding strong support of radiation oncology. We look forward to continued opportunities to work with Congress to protect cancer patients from unnecessary delays in care due to prior authorization.

U.S. House of Representatives
Committee on Small Business
Hearing on Utilization Management:
Barriers to Care and Burdens on Small Medical Practice
September 11, 2019
Testimony
David Walega, M.D.

Chairwoman Velazquez, Ranking Member Chabot, and members of the Committee, thank you for the opportunity to testify before the House Committee on Small Business. I offer this testimony on behalf of the American Society of Anesthesiologists (ASA) and my colleagues who are pain medicine specialists. We are all too familiar with the burdens of prior authorization and the toll it takes on our patients.

I am a physician, board certified in both anesthesiology and pain medicine, currently practicing at Northwestern Memorial Hospital which is part of Northwestern University Feinberg School of Medicine in Chicago. In my clinical practice that spans 19 years, I treat patients suffering from chronic pain and cancer related pain. In my daily practice, I am frequently told by patients and their families that I am the last hope.

As an anesthesiologist with a clinical focus on diagnosis, treatment and rehabilitation of patients with debilitating chronic pain and cancer-related pain conditions, I want to impress upon the Committee the current health care environment in which I practice. Indeed, there are dual crises that confront our healthcare system, an important context for today's discussion.

First, the opioid epidemic, a crisis we've grown accustomed to hearing about in the media. Here, we are finally making measurable progress. Through outreach and education in the medical community, opioid prescribing habits have changed, and the number of opioid prescriptions is down¹. The number of overdose deaths involving prescription opioids has started to decline.² Fearing addiction, patients and providers are seeking all non-opioid treatments, and opt for opioid therapy when no other viable treatment option exists.

Second, is the crisis of chronic pain. The statistics on the prevalence of chronic pain conditions in the U.S. are staggering. In 2011, the National Academy of Medicine (then, known as the Institute of Medicine) reported that over 100 million Americans suffer from chronic pain.³ More recently, the CDC released population-based estimates that show the incidence of chronic pain among U.S. adults ranges from 11% to 40%.⁴

To illustrate the complicated interaction of these dual crises and the predicament many pain specialists like me encounter daily, I'd like to tell you about a patient of mine, whom I will call Betsy, for the sake of this discussion. Betsy was on long-term opioid therapy for nearly 10 years for chronic back pain but under my care, she was able to successfully taper off all opioids so we could implement a non-opioid, evidence based treatment for back pain that has decades of safety and efficacy data available in the peer reviewed literature. Although I can ultimately call her case a "success", success did not come easily to Betsy, her family, nor me. It was only after several treatment denials from her health insurer, months of delays in

¹ There was 22 percent decrease in opioid prescriptions nationally between 2013 and 2017; reported by AMA. Accessed 9/3/19: <https://www.ama-assn.org/press-center/ama-statements/ama-sees-progress-declining-opioid-prescriptions>

² Provisional opioid-involved overdose deaths suggest slight declines from 2017 to 2018, contrasting with sharp increases during 2014–2017 driven by fentanyl overdose deaths; reported in CDC MMWR. Accessed 9/3/19: https://www.cdc.gov/mmwr/volumes/68/wr/mm6834a2.htm?s_cid=mm6834a2_w

³ Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research; Accessed 9/3/19: <http://www.nationalacademies.org/hmd/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-Transforming-Prevention-Care-Education-Research.aspx>

⁴ Prevalence of Chronic Pain and High-Impact Chronic Pain Among Adults, United States, 2016; MMRW, September 14, 2018; Accessed 9/3/19: <https://www.cdc.gov/mmwr/volumes/67/wr/mm6736a2.htm>

care, and being forced to go back on opioids to control her pain during these delays, that we were able to improve her pain, her function and her quality of life.

Betsy is a 38-year-old woman who came to me with chronic back and leg pain for over 10 years. She had been a primary school educator until she had a lifting injury that resulted in severe back pain, for which she underwent spinal fusion surgery, which left her with debilitating pain, and little physical or social function. She was married, had two children with special needs that she was unable to care for independently, leaving much of the responsibility of child rearing to her husband, who was a small business owner with long work hours trying to keep the business running. By the time Betsy and her husband came to my office for consultation, she was depressed, she was unable to sleep through the night due to pain and she was dependent on opioids. Tearfully that day in my office, she pleaded, "Is there anything you can do for me?"

After speaking with her, getting her medical history, examining her and reviewing her spine imaging, I knew Betsy would be an ideal candidate for a non-opioid treatment called spinal cord stimulation (SCS). SCS is a treatment in which we surgically place small electrode wires into the spinal canal adjacent to the spinal cord and deliver imperceptible electrical currents into the spinal cord to block pain signals from reaching the brain. This treatment was first developed in the late 1960s but has obviously advanced with the technological advances we have seen in medicine in the past decade. Multiple clinical studies have shown strong efficacy of this treatment in patients with back pain like Betsy, and SCS is a lifelong successful treatment in well selected patients. It has been shown to decrease pain, improve physical and psychological function, and decrease the need for opioids for pain control.

As with any patient, to ensure SCS would be beneficial to her, I asked Betsy to taper her opioid use by at least 50% before we would proceed with treatment. High doses of opioids can cloud the effects of SCS. We created a tapering schedule for Betsy so she would decrease the dose every few days until we reached our target dose. Not only did she taper, but she actually discontinued all opioids after her consultation with me, showing her strong motivation to get pain relief and change her life for the better.

As is typical with SCS, I first implanted a temporary SCS system for a 10-day trial, which her health insurance provider approved. To measure whether a patient should receive a permanently implanted SCS, the patient must achieve at least a 50% reduction in pain during their trial.

When Betsy returned to my office at the end of her trial in order for me to assess her progress and remove the temporary system, her improvement was nothing less than astounding. She was a completely different person. Her face was bright, she moved around the office without grimacing in pain, and she even laughed. Her husband told me they were able to go for walks in the evenings around the neighborhood, something they hadn't done together in years. She was able to get on the floor of her family room and play with her kids. For the first time in years she was able to sleep for 7 hours without interruption because her pain relief was so profound. She quantified a 75% reduction in pain during this trial period, with improved physical function and she was excited to get the permanent system implanted, which I told her would be a couple of weeks. Indeed, in all manners our expectations with the trial were exceeded.

Per standard practice, I submitted the required forms and letters of medical necessity to her insurer to obtain prior authorization and approval to implant the permanent SCS system. The insurer denied the request on the basis that the treatment was not "medically efficacious." I then appealed the denial. The appeal process took several months. As part of the appeal, I had to connect with another physician reviewer, appointed by Betsy's insurer, for what is called a "peer-to-peer" review. Betsy's fate was then in that individual's hands, not mine.

The concept behind the peer-to-peer review is to assign another physician to objectively review the medical necessity of a proposed treatment, be it a medication, a device, or a surgery, and discuss the case with the appealing physician, to glean more context or nuanced information that is not necessarily clear in the medical records and forms that are provided to insurers when prior authorization for treatment is requested. Unfortunately, "peer to peer" is often a misnomer, as the physician reviewer is usually not a

similarly trained or experienced specialist in the field. In fact, I have had cases wherein a general pediatrician reviewed the medical necessity for a similar case. He did not practice pain medicine, he did not have patients in his practice who had a pain condition that required SCS, and he had never seen nor performed the SCS procedure. He didn't even treat adults, let alone chronic pain. You can imagine how frustrating this interaction can be for a physician trying to establish that your patient's treatment is medically necessary and to effectively advocate for your patient's care.

In this case the appeals process took 8½ months. Feeling hopeless and experiencing her intolerable levels of pain again after the temporary SCS system was removed, we had to place Betsy back on opioid therapy to give her some element of pain relief. We lost whatever gains and progress she had already made. Betsy and her family lost hope all over again, even though we had a proven treatment that was effective for her.

Finally, after an appeal to the medical director of her insurance company, the treatment was approved, despite an unnecessary 8 ½ month delay. She has done extremely well post operatively, remains off opioids for her back pain, is driving a car again, taking care of her kids, and is returning to the workforce.

Though this may seem like an extreme case, I can tell you it is not uncommon.

Her eventual outcome is the reason I became a physician: to help patients live their best lives. But what would have happened had the patient and I not kept on appealing and fighting? I am confident she would still be the completely disabled and opioid dependent mother of two with a poor quality of life—the same person I met when she first came to my office for an evaluation.

I know that I did the right thing for Betsy. In our current practice environment, physicians don't have the time to fight this fight for every patient. These cases take valuable time away from providing care for other patients in need of pain relief. Because of this broken system, more and more physician time and resources are allocated to fighting insurers instead of caring for patients. It's a system built to fail, and to fail all of us.

ASA Recommendations

Remove barriers to comprehensive, multimodal, multidisciplinary pain care

Administrative barriers, such as paperwork, phone calls and the need for specific staff dedicated to prior authorization take time away from patients that deserve comprehensive, individualized care. Barriers or delays in care result from policies imposed by payers, pharmacy benefit or behavioral health management companies even when there are evidence-based, non-opioid treatment options that are available and appropriate.

1. ASA supports increased research and access to evidence-based treatments as part of a multimodal pain care plan. To further efforts to address the opioid crisis, this should include:

- **Medication:** non-opioid pain relievers, anticonvulsants, antidepressants, musculoskeletal agents, anxiolytics as well as opioid analgesics when appropriate.
- **Restorative therapies:** physical therapy, occupational therapy, physiotherapy, therapeutic exercise, osteopathic manipulative therapy (OMT), and other modalities such as massage and therapeutic ultrasound.
- **Interventional procedures:** neuromodulation, radio frequency nerve ablation, peripheral nerve stimulation, central and peripheral nerve ablation, spine surgery and steroid injections, and other emerging interventional therapies.

The health care system, including physicians and patients, are inundated with new laws and regulations, guidelines and policies from payers, PBMs and national organizations, which are often contradictory. **ASA cautions against policies that negatively impact patient care and access to appropriate**

treatments, including one-size fits all prescribing limits or thresholds. ASA urges physicians to make informed prescribing decisions, tailored to the individual patient, in order to reduce opioid related harm. In some cases, a physician may find, after weighing risks versus benefits, that a patient might benefit from opioids prescribed beyond a certain threshold dose recommended by a federal agency, health insurance company, pharmacy chain, pharmacy benefit manager (PBM) or other advisory or regulatory body.

2. **ASA supports a regulatory review of formulary and benefit design by payers and PBMs to ensure that patients have affordable, timely access to evidence-based non-opioid alternatives, pharmacologic and non-pharmacologic.** ASA urges policymakers work closely with physicians to ensure appropriate clinical input. This will help ensure more uniform and comprehensive coverage and access. **ASA recommends:**

- Payers and others are fully transparent when making care decisions and patients and providers have all relevant, necessary information.
- Unanticipated changes to a formulary or a coverage restriction can only be made if appropriate notifications are given in a timely manner and coverage remains for the rest of that year.

3. **ASA supports transparency in care decisions and policies to ensure timely and uninterrupted care for patients.** Physicians and other health care providers want to ensure they provide the most appropriate care for patients. However, these treatments are not always affordable or accessible to patients. **ASA recommends:**

- If a patient is stabilized on a particular treatment or protocol, the health plan or other payer should permit ongoing care to continue while additional authorizations are obtained in order to prevent negative health impacts on patients.
- Payers and others provide clinically relevant information that providers can observe to ensure their patients get the treatments they need.
- Cost alone, without medical justification, should never be the basis of policy decisions.

4. **ASA supports a peer-to-peer policy for prior authorization if a physician in the same field or specialty is assigned to the physician working to obtain approval. ASA recommends:**

- Timely scheduling and flexibility for the peer-to-peer review.
- Prompt decision-making to enable the patient to access or schedule the care.
- Prior authorization approvals remain valid and coverage should be guaranteed for a sufficient period of time to allow patients to access the necessary care.

Remove prior authorization, and other inappropriate burdens or barriers that delay or deny care for FDA-approved medications used as part of medication assisted treatment (MAT) for opioid use disorder

I do not claim to be an addiction specialist, but I have seen first-hand in my practice, the patients that suffer from opioid dependence and experience undesirable side effects. I've assisted those patients with reducing their opioids so that they can successfully taper to a lower dose or eliminate them completely from their pain care regimen. It's no easy feat. However, I have seen patients who were suffering from opioid use disorder (OUD) and I've had to refer them to an addiction expert to get the help they need. At Northwestern, we do not have an addiction services team but when patients present with OUD, we want to assist them with the transition to another provider to ensure they seek treatment.

Recognizing that there is an opioid crisis facing this country, ASA supports measures to ensure patients receive the addiction treatment they need. Evidence-based treatment for OUD should be covered by payers and affordable and accessible to patients.

1. **ASA urges all payers—commercial insurers, self-insured plans, Medicare, Medicaid—as well as PBMs to end prior authorization and other unnecessary utilization management protocols for the treatment of OUD.**
 - There is clear evidence in support of MAT as a proven medical model to support recovery, save lives, reduce crime and improve quality of life.
2. **MAT must be available on the lowest cost-sharing tier to promote affordability as well as prompt availability. Multiple payers in states (e.g. Maryland, New York, Pennsylvania) already have taken these steps—now it is time for all payers to support increased access to MAT.**
 - Timely care is especially important for patients facing addiction. When an individual is ready to seek help, it is essential that their care is not delayed or denied.

Conclusion

First and foremost, we need to address prior authorization because it is bad for patient care. Delays and denials only contribute to further suffering for chronic pain patients.

Practicing at Northwestern, I am fortunate that prior authorization burdens do not financially bankrupt us. However, I recognize that it can be very costly. In one year, my practice dedicated over \$80,000 in resources for prior authorizations. If the same costs and circumstances were incurred in a small group medical practice, it could be financially devastating to have overhead costs rise so high.

For these reasons, I'm appreciative that the Committee is looking critically at this issue and looking for ways to not only help patients and providers, but to ensure that small businesses like medical practices are not harmed by prior authorization burdens.

Thank you for your time and consideration. It was an honor to testify before the Committee. Please do not hesitate to reach out to me or the ASA to discuss any of these recommendations further.



Statement of the American Academy of Family Physicians

By

**John S. Cullen, MD, FAAFP
President
American Academy of Family Physicians**

To

U.S. House Small Business Committee

**Hearing – “Utilization Management: Barriers to Care
and Burdens on Small Medical Practices”**

September 11, 2019

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American Academy of Family Physicians
Page 2 of 10
September 11, 2019

Chairwoman Velázquez, Ranking Member Chabot and members of the Committee; I am Dr. John Cullen, the President of the American Academy of Family Physicians (AAFP), and I am honored to be here today representing the 134,600 physician and student members of the AAFP.

I am a practicing family physician in Valdez, Alaska, a community of about 4,000 people. Along with five family physician colleagues, we are the sole providers for a geographically isolated community 300 miles from the nearest tertiary care hospital. Our census area is about the size of Ohio.

Family physicians conduct approximately one in five of the total medical office visits in the United States per year – more than any other specialty. They deliver care in more than 90 percent of U.S. counties – in frontier, rural, suburban and urban areas. Our members practice in a variety of professional arrangements, including privately owned solo practices as well as large multi-specialty integrated systems and public health agencies.

Family physicians provide comprehensive, evidence-based, and cost-effective primary care dedicated to improving the health of patients, families, and communities. Family medicine's cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient's integrated care team. More Americans depend on family physicians than on any other medical specialty.

Most family physicians in private practice have contractual relationships with seven or more health insurance plans, including Medicare and Medicaid, yet there is no standardization of administrative functions required among public or private payers. Unfortunately, the administrative framework each payer imposes makes practicing family medicine daunting and often demoralizing. As a result, physicians are forced to learn and navigate the rules and forms of each independent payer and plan. Needless to say, this is extremely frustrating and unnecessarily burdensome.

One of the best examples of this burden is the issue of prior authorization. The definition of prior authorization is the process by which physicians must obtain advanced approval from a health plan before the delivery of a procedure, device, supply, or medication in order for insurance to offset the cost for that service. However, I believe there is truth in the description of prior authorizations used in a February 2019, *Medical Economics* [article](#) describing them as “nothing more than insurance companies inserting themselves into the care decision-making process, creating problems for both doctors and patients.”ⁱ

While there may be a limited number of justifiable cases where prior authorization is appropriate, it is clear that health plans more often require prior authorization as a cost-containment strategy by limiting and restricting access to specific services. In submitting prior authorizations, family physicians and their staff spend countless hours reviewing documents, processing paperwork, checking boxes, and waiting on hold to talk to health plans to meet their often arbitrary and not evidence-based requirements so that our patients can get the care they need.

Physicians strive to deliver high-quality medical care in an efficient manner. The frequent phone calls, faxes, and forms physicians and their staff must manage to obtain prior authorizations from prescription drug plans, durable medical equipment suppliers, and others impedes this goal. Even aggressive workflow optimization cannot eliminate the burden of unreasonable and redundant prior authorization requirements.

Impact of Prior Authorization on Patients

The hours physicians squander on prior authorization should be better spent caring for patients, but that is not the only impact on patients. Securing prior authorization for tests, devices, medications, treatments, or procedures often delays the patient's access to necessary care. Appealing a denied request for prior authorization can significantly add to those delays. In a 2018 American Medical Association survey, nearly two-thirds of physicians reported waiting at least one business day to receive prior authorization, while 26 percent waited at least three business days. Further, 28 percent of those surveyed reported the prior authorization process lead to a serious adverse event.ⁱⁱ

This is especially true regarding the health of patients with chronic disease receiving ongoing treatment. Their health should not be threatened by the patient changing health plans. Patients should not be required to repeat or retry step therapy protocols failed under previous benefit plans. Payers should be prohibited from requiring repeated prior authorizations of effective medication management for such patients.

A patient of mine had a combination of Crohn's disease and severe Psoriasis. We were able to control both disorders with Remicade, after trying many other regimens in consultation with specialists over the course of years. Suddenly, we had to pre-authorize this medication which resulted in a delay in care of several months, during which her condition worsened. Remicade must be given every couple of months without a break. When we finally were able to get the medication authorized, she had a serum sickness reaction to it resulting in anaphylactic shock. We nearly lost her. She can now never have a medication that was working extremely well.

Another egregious example of prior authorization is Hydrochlorothiazide, a common and inexpensive first line medication used to treat hypertension. We ended up going back and forth with the insurance companies about what first line agents we had tried. Other thiazide diuretics like Chlorthalidone were unavailable, because he was already on an ACE inhibitor one of the other first line antihypertensives. We spent days on this.

My patients rarely blame their insurance company for this administrivia. They blame me for not getting them the medications they need, yell at my staff, or just stop taking the medications they need to prevent hospitalization. This is the hidden cost of prior authorization. My staff burn out and quit because of the frustration inherent in this crazy system compounded by being yelled at by patients for not having their medications.

Impact of Prior Authorization on Physicians

A study published by Health Affairs on prior authorization and other health insurance plan requirements estimated that primary care physicians spent "significantly more time (mean = 3.5 hours weekly) than medical specialists (2.6 hours) or surgical specialists (2.1 hours)" interacting with health plans.ⁱⁱⁱ This study estimated that the administrative

costs to physician practices spent on interactions with health plans is between \$23 billion to \$31 billion annually.^{iv} Given the growth of prior authorization requirements since this study, the current cost is likely far higher.

I employ both a registered nurse and a medical assistant whose main task is to tackle prior authorizations. Their salaries account for at least 10 percent of my total employee business expense. This is not factoring in the opportunity costs for my or my partner's time spent in useless uncompensated administrative work.

Part of the problem is that it is impossible to know which medications are preferred for each health plan, given that the preferred medications change on a regular basis. My nurse had to spend 45 minutes on the phone with a wildly inappropriate male employee just to find out which medications were preferred. This is repeated on a regular basis.

We don't know what is on the formularies. We have 35 insurance plans we deal with, each with its own system of prior authorization. We often can't write for albuterol because some formularies don't like generic names. It must be Pro Air, unless this is not covered in which case, we substitute Ventolin. These are both Albuterol inhalers. There is no difference. For someone with asthma, they are lifesaving. Our staff has become adept at switching back and forth, but we do not know in advance which will be covered.

This often means that I when I write a prescription, the patients must take it to the pharmacy to find out if it is covered. If it is not, I need to find an alternative, often by writing a new prescription and the process is repeated. I have even had reviewers be confused about the difference between generic and trade name, refusing to cover a medication unless I wrote for the generic, then using the trade name.

A 2016 study published in the *Annals of Internal Medicine* found that primary care physicians spent 27 percent of their time on clinical activities and 49 percent on administrative activities. The authors concluded that primary care physicians spend nearly 50 percent of their time on cumbersome administrative tasks such as prior

authorization, performance measurement and reporting, electronic health record documentation, and care management documentation.^v This inefficiency and time away from patient care is clearly not acceptable.

According to a 2019 AAFP member survey, the highest priority for the AAFP is to reduce physicians' administrative and regulatory burden. Fully 74 percent of respondents said the time spent on administrative tasks has increased since 2018. They cite the greatest administrative burdens as those associated with electronic health record documentation, prior authorization, and quality measure reporting. Prior authorization for prescription drugs was reported to be a task contributing to administrative burden by 88 percent of respondents in our survey. 76 percent indicated prior authorizations for durable medical equipment (DME) contributed to the administrative burden in their practice in the past 12 months. Prior authorization for procedures, including imaging, was reported to be a burden by 79 percent in our member survey. Most troubling is that 84 percent reported that the amount of time they personally spent on administrative functions and tasks associated with patients' care has increased in the past three years. This is a serious problem that is getting worse.

The Quadruple Aim

The Quadruple Aim calls for enhancing patient experience, improving population health, reducing costs, and improving the work life of health care providers.^{vi} The regulatory framework for physician practices drives operating costs up and causes a reduction in meaningful face to face time with patients. The administrative and regulatory burden is one of the top reasons independent physician practices close and is a leading cause of physician burnout. Despite the good intent of underlying health care policies, the burden has expanded to an untenable level and is a significant barrier to achieving the Quadruple Aim.

There are real economic costs to practices of prior authorization. AAFP members have had to hire full-time staff dedicated to handling prior authorizations. But the frustration with prior authorization processes also stems from the fact that the required interactions with payers are not peer to peer conversations. We often hear from members that "for

the person on the other end of the line, their job is to make money for their employer. They do not understand what is in the patient's interest."

Despite all this needless hassle, I have never had a preauthorization turned down, though it has taken a great deal of time out of my day. I spend 15 minutes on hold, providing patient information before being granted a peer to peer conversation. This conversation is usually short unless the reviewer wants to talk about Alaska. My requests for testing for my patients are invariably approved. I do not order unnecessary tests.

The AAFP is committed to work toward tangible solutions to the administrative burden of prior authorization. We are grateful to the House Committee on Small Business for convening this hearing on prior authorization which hinders patients' access to treatment and is an unreasonable burden on physicians. In addition, we appreciate that both the Administration and Congress have recognized the need for administrative simplification in the "Patients Over Paperwork" and the "Medicare Red Tape Relief Project."

Shared Principles for Reducing Administrative Burden

The AAFP and the five other physicians' organizations who collectively make up America's Frontline Physicians have developed [joint principles](#)^{vii} on reducing administrative burden in healthcare. We urge all stakeholders, including Congress, the Administration, payers, and vendors, to adopt policies which adhere to these shared principles which will ensure that patients have timely access to treatment while reducing administrative burden on physicians.

AAFP Policy on Prior Authorization

The AAFP strongly urges the adoption of our prior authorization and step therapy [recommendations](#).^{viii} We call for prior authorization to be standardized and universally electronic to promote efficiency and reduce administrative burdens. The manual, time-consuming processes currently used in prior authorization programs burden family physicians, divert valuable resources from direct patient care, and can inadvertently lead to negative patient outcomes by delaying the start or continuation of necessary treatment.

Family physicians using appropriate clinical knowledge, training, and experience should be able to prescribe medications and order medical equipment without being subjected to prior authorizations. In the rare circumstances when a prior authorization is clinically relevant, the AAFP believes the prior authorization must be evidence-based, transparent, and administratively efficient to ensure timely access to promote ideal patient outcomes.

Generic Medications

Prior authorization should not be required for a patient to obtain generic medications. The AAFP further believes step therapy protocols used in prior authorization programs, in which insurers encourage less expensive prescription drugs to be prescribed prior to more costly alternatives, delay access to treatment and hinder adherence. Therefore, the AAFP maintains that step therapy should not be mandatory for patients already on a course of treatment. Ongoing care should continue while prior authorization approvals or step therapy overrides are obtained.

Durable Medical Equipment

Family physicians also experience prior authorization hassles requesting durable medical equipment or DME. These requests typically require the physician to fill out a paper form or submit specific data for approval, and each DME company has different data requirements for submission. Specifically, the AAFP calls on all payers to simplify the rules surrounding prescription of diabetic supplies. Family physicians simply want to be able to prescribe efficiently and effectively what their patients need to help manage their condition in a way that maintains their health.

This is especially true for patients with diabetes. Unfortunately, many prior authorization rules surrounding the prescribing of diabetic supplies impede this goal and add no discernible value to the care of such patients. If the patient regularly uses quantities of supplies that exceed the utilization guidelines, new documentation to support these supply quantities must be obtained every six months. We understand that glucose testing and other diabetic supplies are an identified area of claims processing errors within the Medicare program and that physicians have a role to play

in fraud prevention. However, the related Medicare requirements have become overly burdensome with little to no value added to the actual care of the diabetic patient. Ideally, it should be acceptable for a physician to write for "diabetic supplies," which would encompass syringes, needles, test strips, lancets, glucose testing machine, etc., with only a need to provide a diagnosis and an indication such a prescription is good for the patient's lifetime.

Furthermore, we request additional improvements for payers to ease the prescribing of DME. Specifically, the AAFP calls for public and private payers to clarify clinician roles and the documentation required in the provision of therapeutic shoes for persons with diabetes. Our members report increasing confusion and frustration resulting from the process by which Medicare's diabetic beneficiaries qualify for and obtain medically necessary therapeutic shoes. In particular with Medicare, the AAFP takes issue with the current requirements imposed that the certifying physician must "obtain, initial, date (prior to signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other MD or DO, physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts" The co-signing requirement detailed above impedes this goal and serves no purpose in furthering patient safety or improving care for patients. The AAFP urges the Congress to direct CMS to eliminate the co-signing requirements for therapeutic shoes for persons with diabetes. We believe this change will result in balanced improvements that clarify provider roles and remove confusion and regulatory inconsistencies in the provision of this medically necessary benefit.

Physicians in Alternative Payment Models

Alternative payment models offer physicians and others the ability to move away from archaic fee-for-service and toward value-based payment arrangements. Physicians who participate in alternative payment models should be exempt from all prior authorization requirements as their financial incentives are already aligned with the payers, so nothing is gained by these burdensome requirements.

Conclusion

The AAFP appreciates the Committee's interest in reducing both barriers to care for patients and administrative burdens on family physicians. We strongly support policy initiatives to eliminate or reduce and streamline prior authorization procedures and these should be aligned and harmonized across all payers – public and private.

By taking steps to standardize and automate prior authorization processes and requirements across the health care system, this will help minimize restrictions that prohibit timely access to medically necessary care.

¹ *Medical Economics*. February 27, 2019 vol. 96 issue 5. <https://www.medicaleconomics.com/business/impact-prior-authorizations>

² <https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf>

³ *Health Affairs (Millwood)*. 2009 Jul-Aug;28(4):w533-43. doi: 10.1377/hlthaff.28.4.w533. Epub 2009 May 14. <https://www.healthaffairs.org/doi/10.1377/hlthaff.28.4.w533>

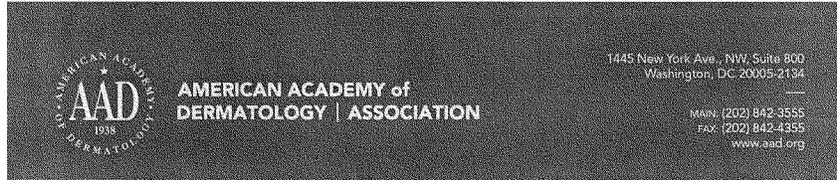
⁴ *Ibid*.

⁵ *Ann Intern Med*. 2016;165(11):753-760. doi: 10.7326/M16-0961 <https://annals.org/aim/article-abstract/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties>

⁶ *Ann Fam Med* November/December 2014 vol. 12 no. 6 573-576 <http://www.annfam.org/content/12/6/573.full>

⁷ <https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/ST-Group6-AdministrativeBurden-061118.pdf>

⁸ <https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/BKG-PriorAuthorization.pdf>



**Statement
of the
American Academy of Dermatology Association**

**U.S. House of Representatives
Committee on Small Business**

"Utilization Management' Barriers to Care and Burdens on Small Medical Practice"

**Presented by
Howard Rogers, MD, FAAD**

September 11, 2019

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Hearing: 'Utilization Management' Barriers to Care and Burdens on Small Medical Practice
September 11, 2019
Page 2 of 8

Introduction

Thank you Chairwoman Velázquez, Ranking Member Chabot, and members of the Small Business Committee for the opportunity to appear before the Committee at this hearing titled "Utilization Management' Barriers to Care and Burdens on Small Medical Practice," and to speak with you about the impact of utilization management on small medical practices. My name is Howard Rogers, and I am testifying on behalf of the American Academy of Dermatology Association, which represents 13,800 dermatologists nationwide. I am a board-certified dermatologist who owns a small private practice, Advanced Dermatology, with two locations in Connecticut. I currently serve on the Academy's Patient Access and Payer Relations Committee and the Council on Government Affairs and Health Policy. I have been in private practice for over 19 years in Connecticut.

Dermatologists diagnose and treat more than 3,000 diseases, including skin cancer, psoriasis, immunologic diseases, and many genetic disorders.¹ One in four Americans suffers or will suffer from a skin disease. As dermatologists are at the forefront of the fight against skin cancer and treating numerous skin diseases, the Academy appreciates the Committee's efforts to prioritize reducing further administrative burden such as utilization management processes. My testimony will focus on how increasing administrative burdens are impacting small medical practices such as my own business. Most importantly, though, I will highlight how prior authorization and step therapy delays necessary care for patients.

Administrative Burdens and the Rise of Practice Costs

Increasing access to high quality care while reducing costs is a goal you hear often throughout the Halls of Congress, by the Administration, and throughout the healthcare system. It is our belief that containing healthcare costs should not come primarily from spending on direct patient care, but rather from curbing administrative costs of care. In a 2017 Medical Group Management Association survey, almost half of the group practices cited administrative burdens costing their practices more than \$40,000 per full-time physician per year to fulfill the requirements of federal regulations. The Medicare Quality Payment Program reported prior authorization requirements as one of the most burdensome to practices.² Physician practices are on the frontline – and complying with management utilization has driven up the cost of running a medical practice. On average, dermatologists dedicate eight hours per week solely to administrative activity; precious time they could be otherwise dedicating to patient care. Prior authorization is one of the most unbalanced

¹ The Academy's *Burden of Skin Disease* briefs are a set of informational resources that capture the scope and importance of various skin conditions, and can be accessed at <https://www.aad.org/about/burden-of-skin-disease/burden-of-skin-disease-briefs>.

² Medical Group Management Association, Regulatory Burden Survey, October 2018, available at <https://www.mgma.com/getattachment/0dcef899-fe2c-4225-ac94-5820df6475cf/MGMA-Regulatory-Relief-Survey-2018.pdf.aspx?lang=en-US&ext=.pdf>

approaches to utilization management in terms of increasing practice costs while providing no increase in quality of care and regularly delaying patient treatment.

The Burden of Prior Authorizations on Physician Practice

Prior authorization is a significant barrier to care that has harmed the patient-physician relationship. The Academy has long advocated for solutions that remove prior authorization policies that adversely affect patient care. For many skin diseases and conditions, medications are specialized and highly nuanced, and their efficacy is dependent on several patient factors. Prior authorization policies that place a third party in a decision-making position, with no knowledge of the complexity or full history of a patient's condition, are not only inappropriate; they also impede a patient's access to the most effective treatment, and a delay can cause irreparable harm. The clinically indicated choice of therapy should be respected and should rest on the patient-physician relationship where all critical factors—including efficacy and safety of all the treatment options, co-morbidities, and support system—are considered, fully discussed, vetted, and prescribed. Preserving the treatment value between physicians and their patients should remain paramount; therefore, prior authorization and associated appeals policies should not encroach on or unduly burden physicians or patients in accessing optimal, medically necessary drug therapies.

In 2016, the Academy conducted a survey of its members regarding the burden of prior authorizations. Over 90 percent of dermatologists reported experiencing an increase in the number of drugs requiring prior authorizations. Over 90 percent also cited prior authorizations as preventing or delaying treatment of the patient. More than two-thirds of dermatologists reported prior authorizations negatively affecting at least one patient per day. On average, dermatologists claim that they completed six prior authorizations a day, taking up to three hours each day. This is a significant cost to dermatology practices, which are small business in your communities. Small and solo practices are forced to hire staff just to administer the prior authorizations for drugs and medical procedures. It is not just dermatologists who are impacted by the burden of prior authorizations. A study by Health Affairs revealed that when the time is converted to dollars, practices spent an average of \$68,274 per physician per year interacting with health plans. This equates to \$23 billion to \$31 billion annually.³ The majority of dermatologists report prior authorizations ultimately get approved after frequent provider appeals. Many describe the mechanism as a tool not to ensure medically necessary treatment, but rather a practice to exhaust providers in the hopes of them

³ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.4.w533>
Health Affairs, *What Does It Cost Physician Practices To Interact With Health Insurance Plans?* VOL. 28, NO. SUPPLEMENT 1: WEB EXCLUSIVES, 2009

abandoning the treatment for the patient. Prior authorization ultimately ends up costing the health care system more than it saves, and furthermore, harms patient care.

To combat the 70 hours a week my office staff was dedicating to prior authorizations, my practice has hired two full time staff at a cost of \$120,000 per year to handle the volume of prior authorizations. Even with extra support staff, providers in my practice are regularly disrupted from patient care to deal with prior authorizations. One quarter of my office's communications, be it phone calls, faxes, emails, or notifications from EHRs or payer portals, are associated with prior authorizations. My practice partner of 15 years with more than 30 years of dermatology experience is in good health and loves seeing patients, but is retiring because of the frustration and difficulty in seeing patients due to the administrative burden of prior authorizations and step therapy. My colleagues and I became physicians to help patients, and prior authorizations are impeding our ability to do that. Imagine diagnosing a patient in severe pain and discomfort, finding a treatment option for them, walking them through how to use the medication and how it will make them feel better, and then not being able to get that medication or waiting weeks for them to get approval, all the while seeing them suffer.

To address the toll prior authorization is taking on patients, physicians, and medical practices, the Academy created a web-based tool that allows members to access a letter for dermatologists to use when submitting prior authorizations for over 30 different drugs. This is one small but important step to help dermatologists manage and expedite the submission of required documentation to an insurance company or pharmacy benefit manager (PBM). To quantify the impact prior authorizations have had on dermatology, I would like to highlight that since this tool launched in March of 2017, more than 45,000 letters have been downloaded, and over 2,900 members have accessed this content. These template letters serve as a starting point for providing some relief to our members and their patients from a burdensome process. They are the most accessed tool on the Academy's Practice Management resource page, and this speaks to the need for a solution to this costly burden on small and solo dermatology practices.

The Increasing Burden of Prior Authorizations and Step Therapy Processes for Drugs

Prior Authorizations for Drugs

We applaud the Administration and Congress's continued focus on increasing competition in the drug market and lowering out of pocket costs for patients. With that being said, the Academy is concerned about a recent statement by a Centers for Medicare and Medicare Services (CMS) official that prior authorizations are needed, particularly in some parts of Medicare. There is absolutely no constructive way to balance prior authorizations while preserving access to care.

The Academy has long advocated for solutions that remove this hindrance to patient care, especially as dermatology is disproportionately impacted by increasing prior authorizations for both generic and brand drugs. We appreciate Congress working to address prior authorizations in the "SUPPORT for Patients & Communities Act" (Public Law No: 115-271), which was enacted into law in October 2018. Congress included language, that the Academy advocated for, to create a standardized electronic prior authorization form for Medicare prescription drugs intended to streamline and reduce prior authorization delays. We applaud CMS for recently proposing prior authorization electronic standards for Part D. Under the standards, dermatologists can use an electronic prescribing system or electronic health record (EHR) with electronic prescribing capabilities to determine in real time whether a plan requires prior authorization for a medication.

This is an important step forward in protecting the value of point-of-care access to medications. We applaud Congress and CMS for building on their previous efforts to require MA and Part D prescription drug plans to provide doctors with real-time access to drug pricing data via EHR or prescribing software, so physicians are informed of beneficiary-specific drug coverage and cost information.

While the proposal moves toward increasing transparency and improving access to necessary medications for patients, we would like to recommend that Congress ensure CMS require plans to offer electronic prior authorization (ePA) transactions that are integrated into prescribers' EHRs. Physicians should not be required to login to a separate portal to access the software. A separate portal often requires the physician to re-enter the medical information or transfer the data, often taking time away that could be spent with patients.

Also, we would like to recommend that while Part D plans must support the National Council for Prescription Drug Plans (NCPDP) transactions, it should not be the only supported method of submitting a prior authorization. This new standard should be an available option for those physicians with access to ePA software. Physicians in rural areas rarely have access to this type of technology and will still need the ability to submit appeals to ensure their patients get access to necessary medications.

The Academy recommends that Congress urge CMS to alleviate the prior authorization burden by requiring MA and Medicare Part D participating plans to shorten the turnaround time for prior authorizations and to extend the length of the prior authorization appeal period. Additionally, patients who are stable on a therapy and switching to a plan where a prior authorization is necessary for that treatment should continue to have access to that same therapy for at least 60 days. The Academy also recommends that CMS encourage plans to provide detailed explanations for prior authorization denials, including the clinical rationale, covered alternative treatment, and details on the provider's

appeal rights. Furthermore, CMS should standardize the prior authorization form across all MA and Medicare Part D plans in order to streamline the process.

Lastly, the Academy urges Congress to call on CMS to continually review the list of drugs requiring prior authorizations. A reduction in the number of drugs subject to prior authorizations, especially those that are commonly approved, should be considered on an annual basis. CMS should also require plans to restrict prior authorizations to outlier clinicians and exempt those who have demonstrated very low denial rates due to their consistent use of evidence-based standards.

Step Therapy

Step therapy protocols, a cost containment tool used by health insurance plans, require patients to try one or more prescription drugs before coverage is provided for a drug selected by the patient's health care provider. We understand the need to contain health care costs, but we are concerned that step therapy strategies for medication and other treatment selection have the potential to impact patient outcomes and quality of life.

Requiring patients to try and fail treatments jeopardizes the health of patients, potentially resulting in dangerous consequences. In some instances, health plans force patients to return to the same treatments that have proven to be ineffective when tried previously under a different health plan. The decision to change plans may occur through no fault of the patient, but rather an employer's decision to change plans.

Further, step therapy interferes with the patient-physician relationship by preventing dermatologists from prescribing drugs they know will provide the best treatment results in the most effective manner. Physicians know their patients' medical histories, which enables them to identify potential contraindications and life-threatening adverse reactions. Retaining physicians' medical judgement in patient treatment plans is a cost-effective way to prevent health care dollars from being used on medications that are not effective. It also protects patients from a prolonged treatment that includes scheduling multiple visits to their physician and spending money on prescription medications that are not effective, not to mention disease progression while the patient waits to receive the effective treatment originally prescribed by the physician.

To avoid these adverse effects of switching therapies and to ensure adherence to a prescribed treatment plan, in the event that a patient switches insurance plans, he or she should not be forced to repeat a step therapy process already completed under the last insurance plan.

With regard to a scenario where a patient is forced to repeat a step therapy protocol, Secretary Azar has even stated, "This is not just injurious to health, it is also penny wise and pound foolish."

Hearing: 'Utilization Management' Barriers to Care and Burdens on Small Medical Practice
September 11, 2019
Page 7 of 8

Due to this dangerous and burdensome practice, we urge members of the Committee to support bipartisan bill H.R. 2279, the "Safe Step Act." It is intended to ensure physicians remain the clinical authority over a patient's care, and to lessen the burden on patients required to go through step therapy protocols instituted by insurance companies. Modeled after state legislation, which the Academy is on record supporting through the State Access to Innovative Medicines (SAIM) Coalition, the bill provides a process for patients to easily access a request for an exception to step therapy protocol. The bill applies to insurance plans regulated by the federal Employee Retirement Income Security Act (ERISA). The bill would also require insurance companies to approve an exception request within three days, or 24 hours in the event of an emergency when the patient's life or health is in danger. A Senate companion bill is expected to be introduced by Senators Lisa Murkowski (R-AK) and Doug Jones (D-AL) in the near future. To date, 27 states have enacted step therapy reform laws.

Prior Authorizations for Medical Procedures Continue to Delay Care

In addition to impeding access to pharmaceutical treatments, prior authorizations are also delaying patient access to necessary dermatologic procedures. Dermatology procedures, such as Mohs Surgery⁴, are complex and often require unpredictable additional procedures while the patient is on the operating table. Dermatologists often do not know the extent of the repair procedure that will be needed prior to receiving the prior authorization for Mohs Surgery. Requiring prior authorization that may take days to receive approval while a patient is in the midst of surgery and being forced to send them home with an open surgical wound increases risk of infection and adds additional cost by requiring patients to return for a second surgical procedure. By prohibiting plans from requiring additional prior authorizations for medically-necessary services, such as closing a surgical wound during Mohs Surgery that already received or did not initially require prior authorization, patients are ensured the best chance of positive outcomes.

To address this burden, we ask that the members of the Committee support the "Improving Seniors' Timely Access to Care Act" (H.R. 3107). This legislation aims to relieve prior authorization burdens for procedures under MA plans, as well as provide transparency to patients and providers.

We appreciate that H.R. 3107 prioritizes the creation and utilization of ePA forms while also requiring MA plans to report to CMS the extent of their use of prior authorization and the rate of approvals or denials. To help ensure timely delivery of care and best outcomes for patients, the Academy has also consistently supported policies that encourage real time prior authorization approvals.

Conclusion

⁴ e, Z., MBA, Eliason, M., MD, FAAD, Callis Duffi, K., MD, FAAD, & Secrest, A., MD, FAAD. (2017). The burden of prior authorizations in a large academic dermatology practice. *Journal of the American Academy of Dermatology*, 76(6).

Hearing: 'Utilization Management' Barriers to Care and Burdens on Small Medical Practice
September 11, 2019
Page 8 of 8

Streamlining prior authorizations and step therapy protocols will help reduce the burden of the process, but it does not take away from the fact that health plans' use of prior authorizations and step therapy often delay much-needed treatment and care to patients. The Academy supports Congress in its efforts to further reduce the volume of unnecessary utilization management processes and its impact on small medical practices.

On behalf of the Academy and its member dermatologists, I thank you for holding this hearing, and for your commitment to maintaining timely access to affordable and effective medications for patients. The Academy looks forward to working with you and asks that you consider including physician stakeholders' opinions in your ongoing hearings. We welcome the opportunity to serve as a future reference to the Small Business Committee on this issue and others to ensure that the physician's perspective on helping patients access needed and affordable treatments and services is considered as the Committee considers the challenges facing small medical practices and the patients they serve.



Statement for Hearing on

“Utilization Management: Barriers to Care and Burdens on Small Medical Practices.”

**Submitted to the
Committee on Small Business**

September 10, 2019

America’s Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA) thank the Committee for focusing on the important issue of utilization management. AHIP and BCBSA’s member health insurance providers are committed to ensuring patients receive clinically-effective, evidence-based, high-value care. While utilization management tools accomplish several things, these tools have been particularly critical in combatting the opioid epidemic. Further, with 65% of physicians reporting that at least 15-30% of care is unnecessary,¹ and national specialty societies coming together through a program called Choosing Wisely to identify tests and procedures commonly used whose necessity should be questioned by patients and consumers, utilization management is an increasingly important tool to ensure that patients receive safe, affordable, effective care. AHIP and BCBSA’s member health insurance providers are committed to improving medical management tools to reduce burden and improve quality and outcomes.

Utilization management, also known as medical management, is used by health plans to protect patient safety; prevent unnecessary, inappropriate, and potentially harmful care; improve and better coordinate care; and increase health care affordability. Examples of medical management approaches include: evidence-based medical necessity review; formulary and provider tiered network designs; prior and concurrent authorization; quantity/dosage limits; and step therapy. Medical management tools are critical to ensure a well-functioning health system. These tools entail significant resources and costs for health plans, are never undertaken lightly, and are

¹ Overtreatment in the United States. Lyu H, et al. PLOS One. Sept. 6, 2017.

overseen by senior physician leadership (e.g., chief medical officers) and staffed with teams of clinicians and experts in evidence-review at our member companies.

Prior Authorization: A Targeted and Effective Form of Medical Management

Prior authorization is one example of effective medical management. Prior authorization takes place when a provider makes a request to the patient's health insurance provider before delivering a treatment or service. If the request is approved, the treatment or service is then covered by the patient's health plan consistent with the terms of that plan. Prior authorization is used to target treatments where there is wide variation in practice and gaps between what the clinical evidence shows and care patients receive. Examples include imaging for low-risk patients before low-risk surgery; imaging for acute low-back pain for the first six weeks after onset, unless there are clinical warning signs; and use of more expensive branded drugs when there are generics available with identical active ingredients. The percentage of covered services and procedures that typically require prior authorization is small—less than 15%.

Prior authorization is most useful in addressing overuse and misuse of treatments and services. For example, prior authorization is often used to:

- Ensure that providers follow nationally recognized care recommendations (e.g., ensure opioid prescribing is consistent with federal guidelines)
- Protect patients from unnecessary and potentially harmful care (e.g., unnecessary exposure to potentially harmful radiation from inappropriate diagnostic imaging, such as computerized tomography (CT) scans for headaches, inappropriate off-label drug use)
- Make sure that a medication is not co-prescribed with another medication that could have dangerous, even potentially fatal, interactions (e.g., opioids and benzodiazepines)
- Ensure that medications are safe, effective, and provide value for specific populations or subpopulations who may be affected differently by a medication (e.g., antipsychotic medications for children and adolescents)
- Ensure that the clinician providing the care has the appropriate training to deliver the care being requested (e.g., limiting prescribing of chemotherapy medications to oncologists)
- Trigger dialogue with clinicians to ensure tailored, patient-focused treatment plans that the patient can follow and that will improve outcomes such as when a patient is being treated for a substance use disorder and has other chronic conditions that need to be carefully managed by multiple specialists
- Ensure that when patients are prescribed a medication such as buprenorphine to treat opioid use disorder, the patient also receives services such as counseling, peer support, or community-based support which are critical to the success of the treatment

When developing prior authorization policies, health plans review information on the use of inappropriate treatments, practice variation for specific services, the extent to which providers deliver care consistent with evidence, safety concerns, and other relevant factors to determine

what services or drugs should be subject to prior authorization. Health plans regularly review the medical services and prescription drugs that are subject to prior authorization and make changes based on new evidence, adherence to recognized standards of care, or, in the case of new and emerging therapies, limited available evidence or safety concerns. These reviews are conducted by Pharmacy and Therapeutics committees with relevant clinical expertise.

Adherence to medical and pharmacy policy is required for network providers except when extenuating circumstances would suggest that an exception may be needed for a particular patient. For the most part, medical policy is managed *without* any pre-authorization requirements. However, consistent with their contracts with providers, health plans have the ability to assess a network provider's performance if retrospective review of their practice patterns shows unwarranted variation may be of concern.

In the case of policies where there is evidence of broad unwarranted variation by providers within a health plan's network, a plan may choose to put in place prior authorization to assure that the patient meets appropriate clinical criteria defined by the established evidenced-based medical or pharmacy policy. The purpose of the prior authorization is to demonstrate that the proposed treatment or procedure is truly indicated for that individual based on clinical evidence.

In addition, health plans have robust processes in place to address circumstances where an individual's attending provider can request an exception to medical management techniques if clinically appropriate. This occurs with step therapy, another type of medical management which encourages prescribers to use prescription drugs that are safe, clinically appropriate, and cost effective before using drugs that could pose safety and complex clinical concerns, have higher costs, or both. Providers can appeal a step therapy requirement if the first prescription drug has been tried (and was ineffective or not well tolerated) or is likely to result in an adverse event for the patient. Health plans take such requests seriously and review requests on an expedited basis for urgent cases.

The Centers for Medicare & Medicaid Services (CMS) has repeatedly recognized prior authorization as a valuable tool to protect patients and the Medicare Trust fund, and has taken a number of actions to thoughtfully expand its use as mentioned below, including expanding Medicare Advantage plans' authority to use prior authorization in conjunction with step therapy for Part B (physician-administered) drugs² and expanding the use of prior authorization in Medicare fee-for-service to additional items and services such as durable medical equipment³ and imaging services.

The Crucial Role of Medical Management in the Opioid Epidemic

² Prior Authorization and Step Therapy for Part B Drugs in Medicare Advantage, CMS. Aug. 7, 2018.

³ Medicare Program; Update to the Required Prior Authorization List of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items That Require Prior Authorization as a Condition of Payment, CMS. April 22, 2019.

Medical management has further demonstrated its value as an effective tool in combatting our country's opioid epidemic. Health plans use medical management tools when addressing pain management in patients to encourage providers to try non-opioid approaches to manage pain, limit opioid dosages and duration to reduce unnecessary opioid prescribing and the potential for diversion and treat opioid use disorder (OUD). As a result, data show that opioid prescribing has meaningfully declined in recent years.

Health plans use prior authorization, for example, to protect patients from dangerous combinations of drugs such as when a patient may be prescribed opioids for pain management and another physician prescribes a benzodiazepine which together may result in impaired breathing or other serious drug interactions. Prior authorization can also be used to limit quantity, daily dosages, and the number of refills, consistent with evidence-based guidelines that promote access to appropriate pain care and reduce the risk of addiction. Health plans have used prior authorization as an effective tool to emphasize the Centers for Disease Control and Prevention guidelines which reflect the industry gold standard for opioid prescribing guidance and encourage providers to carefully monitor their opioid prescribing.

Medical management also promotes safe and effective access to medication-assisted treatment (MAT). According to the National Institutes of Health, MAT has the highest probability of being effective in treating OUD when prescribed and monitored safely. Health plans are committed to providing those who have OUD with access to safe and effective treatment options, including MAT, which involves the use of U.S. Food and Drug Administration-approved medications in combination with counseling and behavioral therapies to treat substance use disorders. Medical management can be used to:

- Ensure that the clinician administering MAT has the required training and regulatory approval
- Make sure MAT medications, when co-prescribed with benzodiazepines or other drugs that depress the central nervous system are carefully managed to reduce the risk of serious side effects
- Work with clinicians to ensure tailored, patient-focused treatment programs are in place to promote adherence and improve outcomes
- Encourage the use of “centers of excellence” for OUD that coordinate with specialized staff and peer recovery specialists
- Monitor members newly prescribed MAT medication to make sure the medication is accompanied by services such as cognitive behavioral counseling, peer support, and community-based support groups.

The Use of Medical Management in Public Programs

The value of medical management and prior authorization has not only been recognized in the private sector but by public programs as well. The Medicare fee-for-service program for example, has used prior authorization since 2017 for certain durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) that are frequently subject to unnecessary utilization. Medicare has also begun implementation of an evidence-based guideline and prior authorization program for advanced diagnostic imaging. Additionally, Medicare has implemented numerous prior authorization demonstration programs for specific services, including repetitive, scheduled non-emergent ambulance transports, non-emergent hyperbaric oxygen therapy, home health services, and power mobility devices. A recent Government Accountability Office report recommended that Medicare continue these prior authorization efforts, estimating that savings from prior authorization demonstrations through March 2017 could be as high as \$1.9 billion.¹ Further, just a few weeks ago, as part of the Fiscal Year 2020 Outpatient Prospective Payment System (OPPS) Proposed Rule, CMS proposed new prior authorization requirements for certain cosmetic-related services as a condition of Medicare payment.

Commitment to Streamlining the Prior Authorization Process

Health insurance providers are committed to reducing unnecessary burden, increasing patient and provider satisfaction and improving quality and outcomes. AHIP and BCBSA and our member health insurance providers worked alongside hospitals, providers and pharmacists to identify a series of recommendations for improving the prior authorization process, including: selective application of prior authorization requirements based on a provider's adherence to evidence, performance, or participation in risk-based contracts; prior authorization program review and volume adjustment to make sure that services requiring prior authorization are current and evidence-based; two-way transparency and communication of prior authorization requirements and clinical information necessary to make determinations; exceptions or special allowances of prior authorization requirements to promote continuity of patient care; and increased automation to improve transparency and efficiency.

AHIP and BCBSA are dedicated to improving the prior authorization process for patients and providers, leveraging the recommendations of the aforementioned multi-stakeholder group. Continued progress will require a willing partnership with the provider community, where the end goal is not to outright ban utilization management tools but to acknowledge the value that these tools provide by protecting patients and promoting affordability, while finding the right balance of these tools so that they do not impede access to timely care.

Ongoing Efforts by Health Plans to Improve the Prior Authorization Process

Building on these recommendations and feedback from health insurance providers, AHIP is conducting a major effort to improve the prior authorization process. These efforts include coordinating a demonstration project with health information technology companies, plans, and providers, to evaluate the impact of automating various components of prior authorization. The project will test prior authorization automation solutions that are as integrated as possible with practice workflow and have the potential for widespread adoption.

BCBSA is a participant on the Office of the National Coordinator's Payer to Provider Task Force, an effort aimed at addressing the interoperability of communications between payers and providers in the clinical data arena, including prior authorizations. BCBSA and member companies have committed funds and resources to federal efforts to make authorization simpler and less burdensome to providers through improved technology solutions.

Both AHIP and BCBSA continue to actively engage with provider organizations to identify ways to improve prior authorization and other medical management tools to ensure patient safety, address the costs of healthcare and reduce administrative burden. In just a few weeks, AHIP will be co-hosting a workshop with America's Physician Groups to explore how medical management and other functions are delegated to physician groups under various risk-sharing arrangements.

Legislation Addressing Medical Management

Efforts are underway in the private sector and within public programs to streamline the use of medical management and prior authorization. Statutory restrictions on medical management will hinder the ability of these tools to address both existing areas of continued misuse as well as future areas yet to be identified. The numerous studies documenting inappropriate care in a variety of settings for different medical procedures, tests and treatments – not to mention the increasing number of emerging therapies entering the market – underscore the continued need for robust tools and strategies that support sound clinical decision-making. AHIP and BCBSA urge the Committee to preserve the flexibility of private payers, medical groups taking on medical management functions and public programs to use these medical management tools to help ensure safe, effective and affordable care for patients.

Conclusion

Needless medical tests harm patients and waste billions of dollars every year; \$200-\$800 billion is wasted annually on excessive testing and treatment.⁴ Medical management ensures patients have access to safe and clinically-effective health care services and addresses this type of waste in our health care system. Health insurance providers are committed to working with stakeholders to ensure medical management tools are used to promote evidence-based care without imposing unnecessary burden.

Thank you for the opportunity to provide these comments. Please contact us if you have questions or would like more information.

⁴ Best care at lower cost: the path to continuously learning health care in America. Institute of Medicine. September 6, 2012.



AMERICAN ACADEMY
OF OPHTHALMOLOGY

**American Academy of Ophthalmology
House Committee on Small Business
"Utilization Management: Barriers to Care and
Burdens on Small Medical Practices"
September 11, 2019**

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Thank you for holding an important hearing on the impact that utilization management tools have on patient care and the burdens that they place on small medical practices. As the world's largest association of eye physicians and surgeons, the Academy seeks to protect sight and empower lives by setting the standards for ophthalmic education and advocating for our patients and the public. According to our latest survey data, fifty-two percent of U.S. practicing Academy members are in solo practice or ophthalmology groups of four or fewer ophthalmologists. Ophthalmology patients with blinding eye disease are among Medicare's most vulnerable patients. The American Academy of Ophthalmology appreciates the opportunity to submit a statement for the record about the impact that utilization management tools have on ophthalmology patients and practices.

Utilization Management and Prior Authorization:

Many physicians feel that they and their staff spend too much time on administrative tasks rather than providing care to patients. Patient care can be negatively impacted when these administrative tasks delay medically necessary care. For example, prior authorization (PA) is a health plan utilization tool that requires providers to obtain approval before performing a service to receive payment. Health insurers are increasingly requiring prior authorization for pharmaceuticals, durable medical equipment and many other medical services, including medically necessary surgeries.

The Academy and much of the ophthalmic community is concerned that prior authorization is already overused and continues to grow. This is compounded by existing processes that are inefficient and lack transparency. The prior authorization approval process, now more than ever, consumes valuable physician and staff time, costs physician practices money and may negatively impact patients by delaying much-needed treatment.

In 2018, the Academy surveyed its members about their experiences with prior authorization. For the more than 400 survey respondents:

- 86 percent reported that PA burdens have increased "significantly" over the past five years.

- 87 percent reported that care is “often” or “always” delayed for those patients whose treatment requires PA.
- 89 percent reported that the PA process can have a “significant” or “somewhat” negative impact on patients’ clinical outcomes.
- 89 percent reported that during the past five years a stable patient was asked to switch from his/her medication by the insurer even though there was no medical reason to do so.
- 94 percent described the burden associated with PA as “high” or “extremely high.”

Many large medical practices have hired additional staff members to work exclusively on PA requests. However, small medical practices may not have the resources necessary to hire staff dedicated to processing PA requests. For small practices this means that the physician(s) must often spend part of their day obtaining PA approvals - time that could be better spent caring for patients.

Prior Authorization under Medicare Advantage Plans:

One in three people with Medicare is enrolled in Medicare Advantage (MA). Federal statute and regulations by the Centers for Medicare and Medicaid Services (CMS) explicitly require MA plans to provide coverage for all services covered under Medicare Parts A and B. The CMS Medicare Managed Care manual further provides that MA plans are “prohibited from implementing policies that are more restrictive than what is covered under Original Medicare.” However, physicians are reporting that MA plans have imposed increasingly onerous PA requirements that do just that. The Academy and many physician groups believe that these PA requirements are not appropriate under Medicare Advantage when medically necessary care would be immediately accessible if the patient were in Part B of fee-for-service (FFS) Medicare.

Numerous ophthalmology patients with age-related macular degeneration need monthly injections of a drug into their eye, twice monthly if both eyes need treatment. In response to members’ complaints about abuse by Medicare Advantage plans in Florida, the Academy identified at least 6 Medicare Advantage plans that are requiring a PA every time that an injection is given. Macular degeneration is a chronic condition that requires long-term treatment. Requiring monthly or more frequent PAs when they are approved in nearly 100 percent of the cases is a waste of time and demonstrates that medically necessary care is being denied. This is just one example of a wasteful burden that delays care, takes time away from patient care and is a misuse of doctors’ time and other resources.

The Office of the Inspector General recently weighed in on service and payment denials by Medicare Advantage plans. PA is a prime method by such plans for delaying or denying medically necessary services. The OIG report raised concerns that denials were driven by corporate profit-seeking behavior. They noted that 75% of appealed denials were overturned. The OIG further stated that prior authorizations were “especially burdensome for beneficiaries with urgent health conditions.” That would be ophthalmology patients with vision-threatening eye diseases such as macular degeneration and diabetic retinopathy.

The Academy is one of the founding members of the Regulatory Relief Coalition (RRC) which includes 10 physician professional organizations dedicated to ensuring that Medicare patients have timely access to medically necessary services through the reduction in administrative burdens — including prior authorization— that divert physician focus away from patient care. Over the past two years, the Academy and RRC members have met with numerous officials at both the Department of Health and Human Services (HHS) and CMS to bring attention to the burdens of excessive PA by Medicare Advantage plans. In August 2019, the RRC submitted comments to CMS' most recent Patients over Paperwork Request for Information (RFI).

The Improving Seniors' Timely Access to Care Act (H.R. 3107):

This problem has gotten the attention of Congress. H.R. 3107, the Improving Seniors' Timely Access to Care Act of 2019, would improve delivery of care by streamlining and standardizing prior authorization in Medicare Advantage. Transparency requirements will help ensure that beneficiaries understand the plans' restrictions on their care and help CMS focus guidance on appropriate use of this utilization review tool. This bipartisan legislation was introduced by Reps. Suzan DelBene (D-WA), Mike Kelly (R-PA), Ami Bera, MD, (D-CA) and Roger Marshall, MD (R-KS) in June 2019.

Based on a consensus statement on prior authorization adopted by leading national organizations representing physicians, hospitals and health plans, H.R. 3107 would facilitate less burdensome electronic prior authorization, improve transparency for beneficiaries and providers alike, and increase CMS oversight on how Medicare Advantage plans use prior authorization.

Many of the steps put forward in the proposed bill could be taken pro-actively by CMS in order to speed burden reduction. Those actions include:

- Create a "real-time" electronic prior authorization process, developed by CMS for items and services that are routinely approved;
- Improve transparency by requiring plans to report to CMS on the extent of their use of prior authorization as well as the rate of approvals or denials;
- Require plans to adopt transparent prior authorization programs that are reviewed annually, adhere to evidence-based medical guidelines, and include continuity of care for individuals transitioning between coverage policies to minimize any disruption in care;
- Hold plans accountable for making timely prior authorization determinations and to provide rationales for denials;
- Prohibit additional prior authorization requests for medically necessary services performed during a surgical or invasive procedure that had already received or did not require prior authorization.

More than 370 national and state organizations representing medical providers, patients and individuals with disabilities are supporting H.R. 3107.

Conclusion:

The demand and need for prior authorization reforms are growing — particularly as more seniors choose Medicare Advantage for their health insurance needs. According to a recently released Kaiser Family Foundation report, “A Dozen Facts About Medicare Advantage in 2019,” Medicare Advantage enrollment has nearly doubled in a decade. One-third (34%) of all Medicare beneficiaries — 22 million people — are enrolled in Medicare Advantage plans, and nearly four out of five enrollees (79%) are in plans that require prior authorization for some services. The Congressional Budget Office (CBO) projects that beneficiaries enrolled in Medicare Advantage plans will rise to nearly half of all Medicare beneficiaries (about 47%) by 2029. Recognizing the need to protect a growing number of Medicare beneficiaries, more than 100 members of Congress called for such reforms in a letter last year to the CMS.

We appreciate the Small Business Committee's interest in issues that impact physicians, particularly those in small practices. For our seniors—and on behalf of our members, whose patient population is comprised in large part by Medicare beneficiaries—the Academy is committed to protect patients from delays in care and relieve unnecessary administrative burdens that impede delivery of timely care. The Academy supports congressional efforts to reduce and streamline the prior authorization process and encourages Committee members to consider cosponsoring H.R. 3107 if they have not already done so. The Academy looks forward to future opportunities to work with Congress to protect ophthalmology patients from unnecessary delays to sight-saving care and is happy to serve as a resource for the Small Business Committee as you continue your review of the impact and burdens of utilization management tools on small medical practices.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

Between 2013 and 2015, the American Academy of Ophthalmology (AAO) received funding from the Agency for Healthcare Research and Quality (AHRQ) under the Developing Evidence to Inform Decisions about Effectiveness (DECIDE) Program, to disseminate the Registry for Glaucoma Outcomes Research (RIGOR) study findings through the use of social media tools.

The American Academy of Ophthalmology is a 501c (6) educational membership association.

United States House of Representatives
Committee on Small Business

Hearing on “Hearing on “Utilization Management: Barriers to Care and
Burdens on Small Medical Practices”

September 11, 2019

Statement of
The American Physical Therapy Association (APTA)

Chairwoman Velazquez, Ranking Member Chabot, and Members of the House Committee on Small Business:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments to the House Committee on Small Business for its hearing “Utilization Management: Barriers to Care and Burdens on Small Medical Practices.”

The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for avoidable health care services. Physical therapists’ roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession’s vision of transforming society by optimizing movement to improve the human experience.

APTA supports efforts to reduce administrative burdens on providers, many of whom are also small business owners. To continue to reduce burdens for health care providers and patients, improve the quality of care, decrease costs, and ensure that patients and their providers are making the best health care choices possible, APTA offers the following recommendations for the committee’s consideration.

Administrative Burdens Challenging the Physical Therapy Profession

Background

Recognizing that administrative burden is a major problem for the physical therapy profession—and health professions in general—easing it is one of APTA’s strategic priorities. To convey the concerns of the physical therapy community to congressional committees and staff, federal and state regulators, state legislators, employers, payers, third-party administrators (TPAs), and others, APTA recently collected objective, measurable findings. From December 2018 to January 2019, the association surveyed 1,599 members (number of responses included after screening criteria was applied to 1,617 returned surveys) on prior authorization, obtaining treatment approval, patient impact, and effects on the profession. The results allow APTA to be specific in articulating the amount of burden on the profession, the greatest burdens being faced, and the toll these burdens are taking on patient outcomes and on the physical therapists and physical therapist assistants who provide services. Below is a summary of our findings:

- 85.2% of providers agree or strongly agree that administrative burden contributes to burnout.
- 76.5% of facilities have added nonclinical staff to accommodate administrative burden.

- Top 5 items identified that would reduce administrative burden are:
 1. Standardization of documentation requirements across all stakeholders (51.5% of respondents)
 2. Standardization of coverage policies across payers (38.1%)
 3. Standardization of prior authorization process (36.0%)
 4. Unrestricted direct access (36.1%)
 5. Elimination of requirement for Medicare plan of care signature and recertification (38.8%)
- Prior authorization is a primary source of burden, with most front desk staff spending more than 10 minutes for an initial prior authorization and a majority of front desk staff and clinicians spending more than 10 minutes when requesting approval for continued visits for patients in all types of health plans.
- 72.5% of respondents wait for a prior authorization from a health plan an average of 3 days or more.
- Nearly 3/4 of respondents indicated that prior authorization requirements delay access to medically necessary care by more than 25%.
- Most respondents indicated that 25% of clinician and staff time would be saved if Congress constructed legislation that requires standardization of prior authorization forms and processes.
- 74% of respondents agreed or strongly agreed that prior authorization requirements negatively impact patients' clinical outcomes.
- More than 3/4 of respondents say prior authorization burden increases by more than 25% when a TPA is involved in the approval process.
- 40% of respondents report that even after a payer has said prior authorization is not required, more than 25% of claims are later denied for that reason.
- 65% percent of respondents say more than 30 minutes of staff time is spent preparing an appeal for 1 claim.
- More than 50% of appealed claims are overturned.

Medicare Fee-for-Service (FFS) Recommendations

Plan of Care Certification Requirements

Pursuant to Medicare Benefit Policy Manual (MBPM) Chapter 15 Section 220, a plan of care must contain diagnoses, long-term treatment goals, and type, amount, duration, and frequency of therapy services. CMS requires physicians/nonphysician practitioners (NPP) to certify a patient's therapy plan of care, meaning a dated signature on the plan of care or some other document that indicates approval of the plan. CMS states in the MBPM that it is not appropriate for a physician/NPP to certify a plan of care if the patient was not under the care of some physician/NPP at the time of the treatment or if the patient did not need the treatment. In certifying an outpatient plan of care for therapy, a physician/NPP is certifying that: services are or were required because the individual needed therapy; a plan for furnishing therapy has been established by a physician/NPP or by the therapist providing such services and is periodically reviewed by a physician; and services are or were furnished while the individual was under the care of a physician. MBPM Chapter 15 further states that there is no Medicare requirement for

an order; however, “when documented in the medical record, an order provides evidence that the patient both needs therapy services and is under the care of a physician.” The MBPM also states that **if the signed order includes a plan of care, no further certification of the plan is required** (emphasis added).

Compliance with the physician signature requirement is a logistical and administrative burden on therapy providers and physicians, taking valuable time and resources away from delivering patient care. Although an unintended consequence, care frequently is delayed while awaiting a physician signature—often after multiple requests—placing the beneficiary’s health at risk due to the delay. Although the physical therapist may have performed due diligence in requesting a physician signature, the financial burden falls on the physical therapist if a signature is not obtained. Moreover, in instances of delayed certifications, the therapist must identify and compile evidence that is necessary to justify the delay, further increasing his or her administrative burden. This is compounded by the frequent lack of physician response, which leaves the therapist with an inadequate paper trail of the interaction.

While the medical record may illustrate the medical necessity of therapy services, CMS contractors will deny payment or seek recoupment if the plan of care is missing a signature, if the signature was not obtained within the required timeframe, or if the signature is of marginal or questionable legibility.

The administrative burden of this regulation is untenable. Physical therapists and other therapy providers should not be held responsible and possibly subject to medical review due to a physician’s inaction. Moreover, the plan of care signature requirement is not consistent with contemporary physical therapist practice. As discussed above, every state, DC, and the USVI all have recognized the safety and benefits of direct access to physical therapy by removing from their statutes all or some of the referral requirements or order provisions for physical therapist evaluation and treatment. Yet, despite all states having adopted direct access, a Medicare beneficiary in most cases obtains an order from a physician/NPP before visiting a physical therapist. (Physical therapists have shared anecdotally that it would be extremely rare for an order to include a plan of care, as it is typically always the therapist who develops the plan of care and then sends to the physician for review/signature.)

When there is an order for therapy in the record, the order demonstrates that the patient is under the care of a physician/NPP and the patient needs therapy. Forcing physical therapists, after developing the plan of care, to send it to the physician for signature (which can take weeks to obtain and often requires multiple follow-up calls and emails), even in the presence of an order, is both burdensome and unnecessary. That said, when a physician/NPP order is present, the therapist would continue to share the plan of care with the physician/NPP, the difference being there would be no requirement for the physician to sign the plan of care and return it to the therapist to indicate approval. When a patient does not have an order, the physical therapy provider would be required to comply with the current plan of care signature requirements.

Recommendation: To reduce significant burden on outpatient therapy providers, Congress should urge CMS to modify the plan of care certification requirement. Barring elimination of this administratively burdensome requirement, CMS should accept either an order signed by a physician/NPP *or* have a plan of care certified by a physician/NPP within 30 days of the initial therapy treatment.

Medicare Advantage Recommendations

Utilization Management

APTA understands and supports reasonable efforts to ensure appropriate utilization of physical therapy services that recognize the physical therapist's ability to render patient-centered care using evidence-based guidelines, clinical judgment and decision-making, and full scope of licensure. However, based on the issues that have been reported to us by our members, access to medically necessary therapy is being delayed or curtailed entirely.

Many utilization management (UM) programs are pervasively flawed and fraught with problems, making providers unable to receive authorization and prompting cancelled visits that result in increased costs to small businesses and in indefinite delays in treatment. The adoption of UM programs by Medicare Advantage (MA) plans has been extremely disorganized and haphazard due to lack of notification, training, and preparation. Ultimately, implementation of these programs has led to widespread confusion and delays in obtaining authorization, inhibiting the delivery of seamless medically necessary care to enrollees. Moreover, implementing UM programs for outpatient therapy services only exacerbates the already overwhelming financial and administrative burdens facing these providers and small businesses, and further disrupts medically necessary care.

Current UM programs exponentially increase administrative burden while adversely impacting access to medically necessary care and creating a systematic focus on volume of services focused solely on volume of service, not outcomes.

Recommendation: Further investigation by this committee on this issue may be warranted, including the impact UM programs have on financial and administrative costs to small businesses and on inappropriately hindered patient access.

Inconsistent Documentation Requirements

A significant burden for providers who treat MA enrollees is that each MA plan has its own documentation requirements, and determining what each plan requires is nearly impossible. For example, plans may have differing requirements for referrals/orders, initial evaluations, progress reports, and treatment notes, etc. Moreover, trying to sort out these requirements takes time away from direct patient care, as plans' requirements often are hidden within policy manuals, plan websites, and/or provider handbooks.

Recommendation: Congress should urge CMS to require all MA plans adopt a single standardized set of documentation requirements.

Inconsistent Application of Definition of Medical Necessity

MA plans state that they follow Medicare guidelines, yet they have confusing interpretations of these guidelines with regard to the use of Correct Coding Initiative edits, the multiple procedure payment reduction, the 8-minute billing rule, etc. The lack of standardized guidelines between original Medicare and MA creates confusion among providers, leading to potential loss of documentation integrity, which ultimately results in limited care coordination and collaboration among health care providers and significant increases provider burden—without improving the quality of care. MA plans commonly use language from the payer’s commercial products and not the Medicare definition, creating even more confusion and misunderstanding, resulting in inappropriate claim denials and delays in patient access.

Recommendation: Congress should urge CMS to standardize the Medicare coverage, coding, and billing guidelines that an MA plan may adopt. Congress should also urge CMS to require that MA plans use the same definition of medical necessity that exists under Medicare Part B.

Prior Authorization

In accordance with the Triple Aim, APTA understands and supports reasonable efforts to ensure appropriate utilization of physical therapy services that recognize the physical therapist’s ability to render patient-centered care using evidence-based guidelines, clinical judgment and decision-making, full scope of licensure, timely patient access to medically necessary services, and streamlined administrative processes. However, current managed care prior authorization programs are not consistent with these objectives. Prior authorization runs contrary to a value-based model and does not facilitate professional judgment or clinical decision-making based on patient presentation. Further, each plan’s instructions for obtaining prior approval for current and ongoing patients are highly variable and often unclear.

Prior authorization substantially increases administrative burden and the possibility of inadvertent error; moreover, it is in direct conflict with contemporary clinical practice. Currently, the majority of MA enrollees must undergo a prolonged, burdensome process to obtain treatment authorizations. A delay in authorization may severely hinder a patient’s recovery, requiring physical therapists and other providers to decide between abiding their ethical obligations by furnishing an uncovered service at their own expense, or risk the patient’s health and well-being by waiting for a plan to authorize medically necessary care. Additionally, the care authorized by the health plan or TPA often disagrees with the health care professional’s recommendations. Protecting MA enrollees from arbitrary care denials and restrictions would help to better ensure patient access to timely, high-quality care that is appropriate for the patient’s condition, to avoid preventable adverse events, and to save plans, providers, and patients from expending resources on unnecessary services.

Recommendation: Congress should enact the Improving Seniors' Timely Access to Care Act of 2019 (H.R. 3107). This bipartisan legislation would reduce health care providers' administrative burden by addressing unnecessary preauthorization requirements, ultimately increasing efficiencies in patient care and improving clinical outcomes. H.R. 3107 would advance and streamline the current system by establishing an electronic prior authorization process that will help ensure timely processing for items and services that need to be approved. Additionally, this bill would require the Secretary of the US Department of Health and Human Services to establish a process for "real-time decisions" for items and services that are routinely approved.

Conclusion

APTA commends the committee for leading the discussion on decreasing administrative burden. We are eager to work with members of Congress and federal agencies to explore policy changes that will allow health care providers to enhance patient outcomes instead of focusing on regulations that are overly burdensome and take time away from patient care.

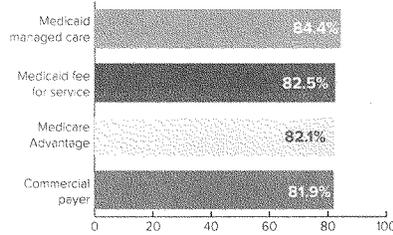


THE IMPACT OF ADMINISTRATIVE BURDEN ON PHYSICAL THERAPIST SERVICES

APTA members report that medically necessary physical therapist services are delayed—ultimately impacting patients’ clinical outcomes—because of the amount of time and resources they must spend on documentation and administrative tasks. The volume of these tasks also leads to dissatisfaction and burnout. APTA urges policymakers and third-party payers to advance policies that streamline documentation requirements, standardize prior authorization and payer coverage policies, and eliminate unnecessary regulations.

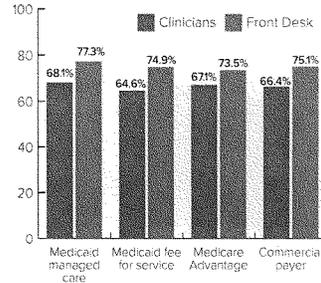
Prior authorization

Percentage of front desk staff who spend more than 10 minutes to complete a prior authorization for each patient enrolled in these health plans



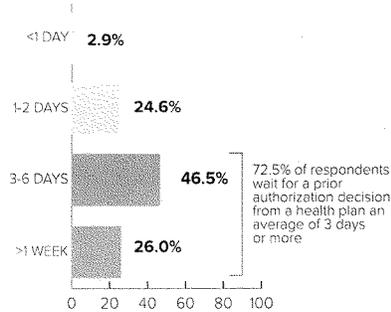
Continued visits

Percentage of clinicians and front desk staff who spend more than 10 minutes when requesting approval for continued visits for each established patient enrolled in these health plans



Nearly 3/4 of respondents indicated that prior authorization requirements delay access to medically necessary care by more than 25%

Average wait time



Amount of clinician and staff time most respondents indicated would be saved if Congress constructed legislation that requires standardization of prior authorization forms and processes

74% OF RESPONDENTS agreed or strongly agreed that prior authorization requirements negatively impact patients’ clinical outcomes

More than 8 out of 10 respondents say administrative burden increases by more than **25%** when a third-party administrator is involved



2 in 5 respondents say that even after a payer has said prior authorization isn't required, more than 25% of claims are later denied for that reason

Ultimate outcome of denied claims



65% percent of respondents say more than 30 minutes of staff time is spent preparing an appeal for 1 claim

Top 5 items that would reduce administrative burden
(numbers represent percentage of respondents)

- 1 **51.5%**
Standardization of documentation requirements across all stakeholders
- 2 **38.8%**
Elimination of requirement for Medicare plan of care signature and recertification
- 3 **38.1%**
Standardization of coverage policies across payers
- 4 **36.1%**
Unrestricted direct access per payer policies
- 5 **36.0%**
Standardization of prior authorization process

85.2% of providers agree or strongly agree that administrative burden contributes to burnout



76.5% of facilities have added nonclinical staff to accommodate administrative burden

Data is from a web-based survey administered Dec 2018-Jan 2019. Sample size: 15,951 | Respondents: 1,617

Respondents were screened to ensure that every participant met at least 1 of these criteria:

- Is an owner/partner of a physical therapy practice;
- Is an administrator/supervisor; and/or
- Provides at least some direct patient care

Remaining respondents after screening: 1,599
Of these:

- 72% practice in outpatient settings
- 33% are owners/partners of a practice
- 62% are administrators/supervisors
- 96% provide at least some direct patient care.



Consensus Statement on Improving the Prior Authorization Process

Our organizations represent health care providers (physicians, pharmacists, medical groups, and hospitals) and health plans. We have partnered to identify opportunities to improve the prior authorization process, with the goals of promoting safe, timely, and affordable access to evidence-based care for patients; enhancing efficiency; and reducing administrative burdens. The prior authorization process can be burdensome for all involved—health care providers, health plans, and patients. Yet, there is wide variation in medical practice and adherence to evidence-based treatment. Communication and collaboration can improve stakeholder understanding of the functions and challenges associated with prior authorization and lead to opportunities to improve the process, promote quality and affordable health care, and reduce unnecessary burdens.

The following five areas offer opportunities for improvement in prior authorization programs and processes that, once implemented, can achieve meaningful reform.

1. **Selective Application of Prior Authorization.** Differentiating the application of prior authorization based on provider performance on quality measures and adherence to evidence-based medicine or other contractual agreements (i.e., risk-sharing arrangements) can be helpful in targeting prior authorization requirements where they are needed most and reducing the administrative burden on health care providers. Criteria for selective application of prior authorization requirements may include, for example, ordering/prescribing patterns that align with evidence-based guidelines and historically high prior authorization approval rates.

We agree to:

- *Encourage the use of programs that selectively implement prior authorization requirements based on stratification of health care providers' performance and adherence to evidence-based medicine*
- *Encourage (1) the development of criteria to select and maintain health care providers in these selective prior authorization programs with the input of contracted health care providers and/or provider organizations; and (2) making these criteria transparent and easily accessible to contracted providers*

- *Encourage appropriate adjustments to prior authorization requirements when health care providers participate in risk-based payment contracts*

2. Prior Authorization Program Review and Volume Adjustment. Regular review of the list of medical services and prescription drugs that are subject to prior authorization requirements can help identify therapies that no longer warrant prior authorization due to, for example, low variation in utilization or low prior authorization denial rates. Regular review can also help identify services, particularly new and emerging therapies, where prior authorization may be warranted due to a lack of evidence on effectiveness or safety concerns.

We agree to:

- *Encourage review of medical services and prescription drugs requiring prior authorization on at least an annual basis, with the input of contracted health care providers and/or provider organizations*
- *Encourage revision of prior authorization requirements, including the list of services subject to prior authorization, based on data analytics and up-to-date clinical criteria*
- *Encourage the sharing of changes to the lists of medical services and prescription drugs requiring prior authorization via (1) provider-accessible websites; and (2) at least annual communications to contracted health care providers*

3. Transparency and Communication Regarding Prior Authorization. Effective, two-way communication channels between health plans, health care providers, and patients are necessary to ensure timely resolution of prior authorization requests to minimize care delays and clearly articulate prior authorization requirements, criteria, rationale, and program changes.

We agree to:

- *Improve communication channels between health plans, health care providers, and patients*
- *Encourage transparency and easy accessibility of prior authorization requirements, criteria, rationale, and program changes to contracted health care providers and patients/enrollees*
- *Encourage improvement in communication channels to support (1) timely submission by health care providers of the complete information necessary to make a prior authorization determination as early in the process as possible; and (2) timely notification of prior authorization determinations by health plans to impacted health care providers (both ordering/rendering physicians and dispensing pharmacists) and patients/enrollees*

4. Continuity of Patient Care. Continuity of patient care is vitally important for patients undergoing an active course of treatment when there is a formulary or treatment coverage

change and/or a change of health plan. Additionally, access to prescription medications for patients on chronic, established therapy can be affected by prior authorization requirements. Although multiple standards addressing timeliness, continuity of care, and appeals are currently in place, including state and federal law and private accreditation standards, additional efforts to minimize the burdens and patient care disruptions associated with prior authorization should be considered.

We agree to:

- *Encourage sufficient protections for continuity of care during a transition period for patients undergoing an active course of treatment when there is a formulary or treatment coverage change or change of health plan that may disrupt their current course of treatment*
- *Support continuity of care for medical services and prescription medications for patients on appropriate, chronic, stable therapy through minimizing repetitive prior authorization requirements*
- *Improve communication between health care providers, health plans, and patients to facilitate continuity of care and minimize disruptions in needed treatment*

5. **Automation to Improve Transparency and Efficiency.** Moving toward industry-wide adoption of electronic prior authorization transactions based on existing national standards has the potential to streamline and improve the process for all stakeholders. Additionally, making prior authorization requirements and other formulary information electronically accessible to health care providers at the point-of-care in electronic health records (EHRs) and pharmacy systems will improve process efficiencies, reduce time to treatment, and potentially result in fewer prior authorization requests because health care providers will have the coverage information they need when making treatment decisions. Technology adoption by all involved stakeholders, including health care providers, health plans, and their trading partners/vendors, is key to achieving widespread industry utilization of standard electronic prior authorization processes.

We agree to:

- *Encourage health care providers, health systems, health plans, and pharmacy benefit managers to accelerate use of existing national standard transactions for electronic prior authorization (i.e., National Council for Prescription Drug Programs [NCPDP] ePA transactions and X12 278)*
- *Advocate for adoption of national standards for the electronic exchange of clinical documents (i.e., electronic attachment standards) to reduce administrative burdens associated with prior authorization*
- *Advocate that health care provider and health plan trading partners, such as intermediaries, clearinghouses, and EHR and practice management system vendors, develop and deploy software and processes that facilitate prior authorization automation using standard electronic transactions*
- *Encourage the communication of up-to-date prior authorization and step therapy requirements, coverage criteria and restrictions, drug tiers, relative*

costs, and covered alternatives (1) to EHR, pharmacy system, and other vendors to promote the accessibility of this information to health care providers at the point-of-care via integration into ordering and dispensing technology interfaces; and (2) via websites easily accessible to contracted health care providers

United States House of Representatives Committee on Small Business

Hearing on

*“Utilization Management: Barriers to Care and Burdens on
Small Medical Practices”*

September 11, 2019

Statement of

Dr. Josh Bailey, PT, DPT
CEO, Rehabilitation Associates

On behalf of

The Virginia Physical Therapy Association

Chairwoman Velazquez, Ranking Member Chabot, and Members of the House Committee on Small Business:

I am Dr. Josh Bailey. I am a physical therapist and CEO of Rehabilitation Associates, a physical therapy business based in Lynchburg, Virginia. On behalf of the Virginia Physical Therapy Association, I want to thank you for the opportunity to provide my perspective regarding the impacts of growing administrative burdens on small PT practices, the towns in which we practice, and the patrons in those towns who depend on us to return them to full function after an accident or injury. I hope to share with you my perspective on how increasing administrative burden impacts the quality of care of our patients, the cost of care, and the quality of life of the practitioner.

Background

Rehab Associates was the first independent physical therapy practice in Central Virginia, opening just over 53 years ago. Our initial office was built with the primary goal of providing high-quality orthopedic physical therapy at fair price and in a convenient manner—being close to where people live and work. Each time that we have expanded over the last 50 years, we have done so to provide value-based services to communities in need. We become engrained in each of the communities in which we work. Spending our time serving churches, providing sideline coverage to local high schools for sporting events, sitting on the boards of local nonprofits, and sponsoring little league sports are just a few ways we serve our communities. It was these consistent values that convinced me to join this organization nearly 23 years ago.

Impact of Utilization Management

Rehab Associates has provided me with the opportunity to care for local friends and family, lead younger physical therapists to deliver compassionate care at the highest level of their licensure, and expand our services to areas that would otherwise be underserved. In more recent years, the growing issue of utilization management is functionally stalling our ability to extend these service opportunities as we have done in the past.

Administrative burdens—such as prior authorization, other forms of utilization management, and denied claims—pull providers and their staff away from caring for patients by requiring extended periods on the telephone or completing authorization forms online. In a survey recently performed by the American Physical Therapy Association (APTA), nearly three quarters of respondents indicated that prior authorization requirements delayed access to medically necessary care by more than 25%. Additionally, the time required to complete those requirements impacts productivity and thus produces a financial burden. To provide an example, it is not uncommon to spend 20-30 minutes on a call to start an appeal process on a single denied claim. This is compounded by the fact that 10-13% of all claims filed are denied.

Burden on Small-Practice Owners

The challenges noted above are not unique to my practice. Along with being the CEO of Rehabilitation Associates, I also serve as the president of the Virginia Physical Therapy Association. There are over 500 small physical therapy practice owners in Virginia. I have spoken to many of them, and they report the same concerns that I have expressed. Many have reported to me that they have contemplated closing or selling their practice due to the overwhelming increase in administrative burdens that limit their ability to care for patients and be paid for their services. Simply put, they cannot provide the type of care that they went into business to provide. They also share that they feel that these administrative issues have limited the longevity of their staff which, in turn, limits their growth potential. Functionally, these administrative burdens drive clinical burnout. I can empathize, as I recently lost a provider to the banking industry. He left the field of physical therapy because increased requirements have made it more difficult to obtain authorization to care for patients. This directly impacted his ability to grow his income and provide for his family. Although this may seem dramatic, it becomes easier to conceptualize when you recognize that over 80% of commercial payers have some form of prior authorization.

Administrative burdens produce a vicious cycle. Authorization must be achieved in order to provide care, and thus treatment is delayed. Once services are provided, third party-payers often dictate which services can be provided and even how much of those services are necessary. Even with authorization, there is still a fair risk for denials, which require additional time to research and appropriately mitigate in an attempt to ensure payment. Denied claims produce delayed payment, which financially stretches practice owners, like me, to make ends meet, as I need to pay the staff who are responsible for billing and providing the services. As this process continues to grow, one must ask: When does it end?

Recommendation

There is current legislation before Congress that would be a good first step in addressing this issue as it relates to at Medicare Advantage (MA) plans. I urge Congress to enact the *Improving Seniors' Timely Access to Care Act of 2019* (H.R. 3107). This legislation, sponsored by Reps Suzan DelBene (D-WA), Mike Kelly (R-PA), Roger Marshall (R-KS), and Ami Bera (D-CA), would reduce unnecessary burden and increase efficiencies. This in turn would allow health care providers to spend more time focusing on their patients instead of on time-consuming administrative tasks that do nothing to further the delivery of care.

Congress must act to remove the unnecessary burdens that have been impacting patients and providers alike. H.R. 3107 would require MA plans to report to the Centers for Medicare & Medicaid Services (CMS) on the extent of their use of prior authorization and the rate of approvals or denials. Increasing the transparency associated with delays in accessing care caused by prior authorization would ensure accountability and help to inform potential next steps to improving patient access.

Conclusion

I applaud the committee for leading the discussion on the impact of utilization management on small practice and the patients we serve. Efforts to address this issue will ensure that health care providers will have more time to do what they were trained to do—attend to their patients and provide them with the care that they deserve.

September 9, 2019

Dear Members of Congress:

The undersigned patient, physician, health care professional, and other health care stakeholder organizations strongly support the *Improving Seniors' Timely Access to Care Act of 2019* (H.R. 3107) recently introduced by Reps. Suzan DelBene (D-WA), Mike Kelly (R-PA), Roger Marshall, MD (R-KS), and Ami Bera, MD (D-CA). This bipartisan legislation would help protect patients from unnecessary delays in care by streamlining and standardizing prior authorization under the Medicare Advantage program, providing much-needed oversight and transparency of health insurance for America's seniors. We urge you to join your colleagues in supporting this important legislation.

Based on a [consensus statement](#) on prior authorization reform adopted by leading national organizations representing physicians, medical groups, hospitals, pharmacists, and health plans, the legislation would facilitate electronic prior authorization, improve transparency for beneficiaries and providers alike, and increase Centers for Medicare & Medicaid Services (CMS) oversight on how Medicare Advantage plans use prior authorization. Specifically, the bill would:

- Create an electronic prior authorization program including the electronic transmission of prior authorization requests and responses and a real-time process for items and services that are routinely approved;
- Improve transparency by requiring plans to report to CMS on the extent of their use of prior authorization and the rate of approvals or denials;
- Require plans to adopt transparent prior authorization programs that are reviewed annually, adhere to evidence-based medical guidelines, and include continuity of care for individuals transitioning between coverage policies to minimize any disruption in care;
- Hold plans accountable for making timely prior authorization determinations and to provide rationales for denials; and
- Prohibit additional prior authorization for medically-necessary services performed during a surgical or invasive procedure that already received, or did not initially require, prior authorization.

The demand and need for such reforms is growing — particularly as more seniors choose Medicare Advantage for their health insurance needs. According to a recently released Kaiser Family Foundation report, "*A Dozen Facts About Medicare Advantage in 2019*," Medicare Advantage enrollment has nearly doubled in a decade. One-third (34%) of all Medicare beneficiaries — 22 million people — are enrolled in Medicare Advantage plans, and nearly four out of five enrollees (79%) are in plans that require prior authorization for some services. The Congressional Budget Office (CBO) projects that beneficiaries enrolled in Medicare Advantage plans will rise to nearly half of all Medicare beneficiaries (about 47%) by 2029. Recognizing the need to protect a growing number of Medicare beneficiaries, more than 100 members of Congress called for such reforms in a [letter](#) last year to the CMS.

For our seniors — and as representatives of organizations seeking to protect patients from delays in care and relieve unnecessary administrative burdens that impede delivery of timely care—we are committed to advancing this legislation in Congress and ask that you join Representatives DelBene, Kelly, Marshall, and Bera in co-sponsoring H.R. 3107 and securing its enactment.

Thank you.

Sincerely,

ACCSES
Aimed Alliance
Alliance for Aging Research
Alliance for Balanced Pain Management
Alliance for Patient Access
Alliance of Specialty Medicine
Alzheimer's Association
Alzheimer's Impact Movement
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology – Head and Neck Surgery
American Academy of PAs
American Academy of Physical Medicine & Rehabilitation
American Academy of Sleep Medicine
American Alliance of Orthopaedic Executives
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Nurse Practitioners
American Association of Orthopaedic Surgeons
American Association of Pediatric Ophthalmology and Strabismus
American Association on Health and Disability
American Autoimmune Related Diseases Association
American Brain Coalition
American Cancer Society Cancer Action Network
American Clinical Laboratory Association
American Clinical Neurophysiology Society
American College of Allergy, Asthma and Immunology
American College of Cardiology

American College of Emergency Physicians
American College of Gastroenterology
American College of Mohs Surgery
American College of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Congress of Rehabilitation Medicine
American Dance Therapy Association
American Gastroenterological Association
American Geriatrics Society
American Glaucoma Society
American Group Psychotherapy Association
American Liver Foundation
American Medical Association
American Medical Rehabilitation Providers Association
American Medical Women's Association
American Music Therapy Association
American Nurses Association
American Occupational Therapy Association
American Osteopathic Association
American Osteopathic Colleges of Ophthalmology and Otolaryngology
American Physical Therapy Association
American Psychiatric Association
American Psychoanalytic Association
American Society for Clinical Pathology
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society for Radiology and Oncology
American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract & Refractive Surgery
American Society of Clinical Oncology
American Society of Echocardiography
American Society of Hematology
American Society of Interventional Pain Physicians
American Society of Nephrology
American Society of Neuroimaging
American Society of Neuroradiology
American Society of Nuclear Cardiology
American Society of Ophthalmic Plastic and Reconstructive Surgery
American Society of Plastic Surgeons

American Society of Retina Specialists
American Society of Transplant Surgeons
American Spinal Injury Association
American Urological Association
American Uveitis Society
American Vein & Lymphatic Society
American-European Congress of Ophthalmic Surgery
America's Physician Groups
Arthritis Foundation
Association for Molecular Pathology
Association of Academic Physiatrists
Association of American Medical Colleges
Association of Black Cardiologists
Association of Rehabilitation Nurses
Association of University Professors of Ophthalmology
Beyond Type 1
Brain Injury Association of America
Bridge the Gap - SYNGAP Education and Research Foundation
Cancer Support Community
CancerCare
Caregiver Action Network
Child Neurology Foundation
Children with Diabetes
Christopher & Dana Reeve Foundation
Clinician Task Force
CMSC- Consortium of Multiple Sclerosis Centers
Coalition For Headache And Migraine Patients
College Diabetes Network
College of American Pathologists
Community Oncology Alliance
Congress of Neurological Surgeons
Cornea Society
Crohn's & Colitis Foundation
Delaware Academy of Ophthalmology
Depression and Bipolar Support Alliance
Derma Care Access Network
Diabetes Patient Advocacy Coalition
DiabetesSisters
Digestive Disease National Coalition
Disability Rights Education and Defense Fund
Dystonia Advocacy Network
Dystonia Medical Research Foundation
Epilepsy Foundation
Eye and Contact Lens Association
Eye Bank Association of America

Federation of American Hospitals
Free2Care
GBS|CIDP Foundation International
Global Alliance for Behavioral Health and Social Justice
Global Healthy Living Foundation
Global Liver Institute
Healthcare Information and Management Systems Society
Hematology/Oncology Pharmacy Association
IFAA - International Foundation for Autoimmune & Autoinflammatory Arthritis
International Essential Tremor Foundation
International Foundation for Gastrointestinal Disorders
International Society for the Advancement of Spine Surgery
Interstitial Cystitis Association
Lupus and Allied Diseases Association, Inc.
Medical Group Management Association
METAvivor
Movement Disorders Policy Coalition
Multiple Sclerosis Association of America
National Alopecia Areata Foundation
National Association for the Advancement of Orthotics & Prosthetics
National Association of Rural Health Clinics
National Association of Social Workers
National Association of Spine Specialists
National Association of State Head Injury Administrators
National Association of State Mental Health Program Directors
National Comprehensive Cancer Network
National Diabetes Volunteer Leadership Council
National Health Council
National Infusion Center Association
National Lipid Association
National Medical Association, Ophthalmology Section
National Multiple Sclerosis Society
National Osteoporosis Foundation
National Pancreas Foundation
National Patient Advocate Foundation
NephCure Kidney International
North American Neuro-Ophthalmology Society
Ocular Microbiology and Immunology Group
Outpatient Endovascular and Interventional Society
Partnership to Advance Cardiovascular Health
Partnership to Fight Chronic Disease
Partnership to Improve Patient Care
Prevent Blindness
Pulmonary Hypertension Association
Remote Cardiac Services Provider Group

Renal Physicians Association
Restless Legs Syndrome Foundation
RetireSafe
Sjogren's Syndrome Foundation
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Critical Care Medicine
Society of Gynecologic Oncology
Society of Hospital Medicine
Spine Intervention Society
The Headache and Migraine Policy Forum
The Leukemia & Lymphoma Society
The Marfan Foundation
The Michael J. Fox Foundation for Parkinson's Research
The Retina Society
The Society of Thoracic Surgeons
Tourette Association of America
Treatment Communities of America
Uniform Data System for Medical Rehabilitation
United Spinal Association
US Hereditary Angioedema Association

Alabama Academy of Ophthalmology
Alabama Society for the Rheumatic Diseases
Lakeshore Foundation
Medical Association of the State of Alabama
Neurosurgical Society of Alabama
Alaska Rheumatology Alliance
Alaska Society of Eye Physicians and Surgeons
Denali Oncology Group Alaska Chapter ASCO
Arizona Medical Association
Arizona Neurosurgical Society
Arizona United Rheumatology Alliance
The Arizona Clinical Oncology Society
Arkansas Medical Society
Arkansas Ophthalmological Society
Arkansas Rheumatology Association
Association of Northern California Oncologists
California Academy of Eye Physicians and Surgeons
California Association of Neurological Surgeons
California Medical Association
California Rheumatology Alliance
Medical Oncology Association of Southern California, Inc.
Cedars/Aspens, non-profit society of ophthalmic surgeon educators
Colorado Medical Society

Colorado Neurosurgical Society
Colorado Rheumatology Association
Colorado Society of Eye Physicians and Surgeons
Connecticut Rheumatology Association
Connecticut Society of Eye Physicians
Connecticut State Medical Society
Delaware Society for Clinical Oncology
Delaware State Neurosurgical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association
Florida Neurosurgical Society
Florida Society of Clinical Oncology
Florida Society of Ophthalmology
Florida Society of Rheumatology
Georgia Society of Clinical Oncology
Georgia Society of Rheumatology
Medical Association of Georgia
Hawaii Medical Association
Hawaii Society of Clinical Oncology
Association of Idaho Rheumatologists
Idaho Medical Association
Idaho Society of Ophthalmology
Illinois Medical Oncology Society
Illinois Society of Eye Physicians & Surgeons
Illinois State Medical Society
Illinois State Neurosurgical Society
Indiana Academy of Ophthalmology
Indiana Chapter, American College of Cardiology
Indiana Oncology Society
Iowa Medical Society
Iowa Oncology Society
Midwest Neurosurgical Society
Kansas Chapter, American College of Cardiology
Kansas Hospital Association
Kansas Medical Society
LeadingAge Kansas
Midwest Rheumatology Association
Kentucky Academy of Eye Physicians and Surgeons
Kentucky Association of Medical Oncology
Kentucky Chapter, American College of Cardiology
Kentucky Medical Association
Louisiana Academy of Eye Physicians and Surgeons
Louisiana Chapter, American College of Cardiology
Louisiana Neurosurgical Society

Louisiana State Medical Society
Rheumatology Alliance of Louisiana
Maine Medical Association
Maine Society of Eye Physicians and Surgeons
Maryland Chapter, American College of Cardiology
Maryland DC Society of Clinical Oncology
Maryland Society for the Rheumatic Diseases
Maryland Society of Eye Physicians and Surgeons
MedChi, The Maryland State Medical Society
Massachusetts Society of Clinical Oncologists
Massachusetts Medical Society
Michigan Society of Eye Physicians and Surgeons
Michigan Society of Hematology & Oncology
Michigan State Medical Society
Minnesota Medical Association
Minnesota Neurosurgical Society
Mississippi Arthritis and Rheumatism Society
Mississippi Oncology Society
Mississippi State Medical Association
Missouri Oncology Society
Missouri Society of Eye Physicians & Surgeons
Missouri State Medical Association
Montana Medical Association
Montana Neurosurgical Society
Montana State Oncology Society
Nebraska Chapter, American College of Cardiology
Nebraska Medical Association
Nebraska Rheumatology Society
Nevada State Medical Association
Northern New England Clinical Oncology Society
New Hampshire Medical Society
Medical Oncology Society of New Jersey
Medical Society of New Jersey
New Jersey Academy of Ophthalmology
New Jersey Neurosurgical Society
The Medical Oncology Society of New Jersey
New Mexico Medical Society
Empire State Hematology & Oncology Society
Empire State Hematology and Oncology Society
Medical Society of the State of New York
New York State Neurosurgical Society
New York State Ophthalmological Society
New York State Rheumatology Society
North Carolina Medical Society
North Carolina Rheumatology Association

North Carolina Society of Eye Physicians & Surgeons
North Dakota Medical Association
North Dakota Society of Eye Physicians and Surgeons
Ohio Association of Rheumatology
Ohio Chapter, American College of Cardiology
Ohio Hematology Oncology Society
Ohio Ophthalmological Society
Ohio State Medical Association
Ohio State Neurosurgical Society
Oklahoma Academy of Ophthalmology
Oklahoma Chapter, American College of Cardiology
Oklahoma Neurosurgical Society
Oklahoma State Medical Association
Oregon Academy of Ophthalmology
Oregon Medical Association
Oregon Rheumatology Alliance
Oregon Society of Medical Oncology
Pennsylvania Academy of Ophthalmology
Pennsylvania Medical Society
Pennsylvania Neurosurgical Association
Pennsylvania Rheumatology Society
Philadelphia Rheumatism Society
Pittsburgh Ophthalmology Society
Pennsylvania Society of Oncology & Hematology
The Hospital and Healthsystem Association of Pennsylvania
Puerto Rico's Hematology and Medical Oncology Association
Rhode Island Chapter, American College of Cardiology
Rhode Island Medical Society
Rhode Island Neurosurgical Society
Rhode Island Society of Eye Physicians and Surgeons
South Carolina Medical Association
South Carolina Oncology Society
South Carolina Rheumatism Society
South Carolina Society of Ophthalmology
South Dakota Academy of Ophthalmology
South Dakota State Medical Association
Tennessee Chapter, American College of Cardiology
Tennessee Medical Association
Tennessee Rheumatology Society
State of Texas Association of Rheumatologists
Texas Medical Association
Texas Ophthalmological Association
Society of Utah Medical Oncologists
Utah Medical Association
Utah Ophthalmology Society

Vermont Medical Society
Medical Society of Virginia
Virginia Association of Hematologist & Oncologist
Virginia Chapter, American College of Cardiology
Virginia Society of Eye Physicians and Surgeons
Neurosurgical Society of the Virginias
Washington Academy of Eye Physicians and Surgeons
Washington Rheumatology Alliance
Washington State Medical Association
Washington State Medical Oncology Society
West Virginia Academy of Eye Physicians & Surgeons
West Virginia State Medical Association
West Virginia State Rheumatology Society
Wisconsin Academy of Ophthalmology
Wisconsin Association of Hematology & Oncology
Wisconsin Medical Society
Wisconsin Rheumatology Association
Wisconsin State Neurosurgical Society
Wyoming County Community Health System
Wyoming Medical Society
Wyoming Ophthalmological Society

